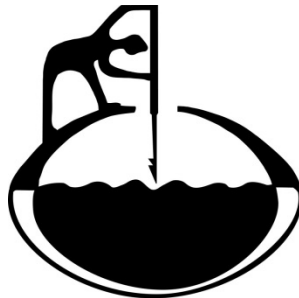


Cancer Control Continuum Gap Analysis: Inventory of Current Policy and Environmental Strategies

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Introduction

Cancer Control Continuum Gap Analysis

Received The Alaska Department of Health and Social Services (DHSS), Division of Public Health (DPH), Chronic Disease Prevention and Health Promotion Section is working with the Centers for Disease Control and Prevention (CDC) to develop a Comprehensive Cancer Control Program. “Comprehensive cancer control (CCC) is a process through which communities and partner organizations pool resources to reduce the burden of cancer. These combined efforts help to reduce cancer risk, find cancers earlier, improve treatments, and increase the number of people who survive cancer.”¹

The Institute of Social and Economic Research (ISER) has been asked by the Section to conduct a cancer control continuum gap analysis. The cancer care continuum includes:

- Prevention (education and outreach)
- Detection (screening)
- Diagnosis
- Treatment
- Survivorship and end-of-life/palliative care

A gap analysis forces an organization to reflect on where an issue is now and to ask where the organization wants it to be in the future. This analysis has explored both current policies that have been enacted in Alaska at the state and federal level, and those that are acknowledged at a national level. The gap analysis is designed to inform the State DHSS as it takes steps to develop a policy agenda for comprehensive cancer control that aims to; reduce the risk of developing cancer, identify cancer earlier, improve cancer treatment, and increase the number of cancer survivors.²

This gap analysis summarizes the results from a literature review focusing on identifying and compiling cancer-related policies across the cancer continuum. This report is an environmental policy scan that includes additional information, where relevant, related to areas that will inform Alaska’s cancer control continuum, including Alaskan data on cancer incidence and prevalence (cancer burden), and data on Alaskans’ health behaviors related to cancer (cancer risk factors) such as smoking and chewing tobacco, delaying cancer screenings, etc.

Focus and Definitions

This analysis focuses on cancer related policy and environmental strategies. The WHO states that “health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society”.³ For the purposes of this report, environmental level strategies are defined as interventions that change, or would change, the context to make healthy options the default choice, so that “individuals would have to expend a significant effort not to benefit from them,” including designing the built environment to promote physical activity, limiting access to unhealthy foods, or passing smoke-free laws.⁴ We have considered environmental level strategies at both the national and state levels.

With such a vast array of information available across the cancer continuum, we felt the need to establish guidelines early in the process to focus our efforts. Aligned with the focus of an environmental scan, we have maximized our search for breadth of knowledge across the cancer continuum, and this does not represent an in depth policy analysis. Consequently, we limited our initial search for relevant state/federal policies in laws (statutes), regulations, and environmental changes to only those acknowledged by national governmental organizations and their affiliates, such as the Centers for Disease Control and Prevention (CDC), the US Department of Health and Human Services, and The National Cancer Institute. With these guidelines in place, our research on prevention and detection yielded substantial results. However, as we researched the diagnosis, treatment, survivorship and end-of-life/palliative care sections, we found that we had to expand our sources to include professional organizations and nonprofits recognized in the cancer field, and peer reviewed articles to gather sufficient representative materials. Our review of Alaskan policies and environmental strategies includes only state laws and initiatives that coincided with our findings.

This analysis provides an initial inventory of policies and environmental strategies across the cancer continuum to assist Alaska cancer experts in determining where Alaska and Federal policies and strategies align and differ along the cancer continuum.

Prevention

Cancer can be prevented by avoiding tobacco, eating a healthy diet, preventing obesity, being physically active, reducing alcohol consumption, and avoiding UV radiation, as well as through screenings for colorectal and cervical cancer and vaccination against HPV and Hepatitis B.⁵ However, the Comprehensive Cancer Control Board emphasizes the primary prevention of cancer as a priority, focusing on:

- “Reduction of tobacco use and exposure
- Improvement in nutrition and physical activity
- Sun safety
- The use of vaccines to prevent cancer
- Reduction of radon exposure.”⁶

Consequently, the prevention areas of focus detailed in this report will be limited to the five identified priorities listed above. Additional information on screenings that prevent colorectal and cervical cancer will be detailed in the section on Cancer Diagnosis and Detection: Screening.

Tobacco Use and Exposure

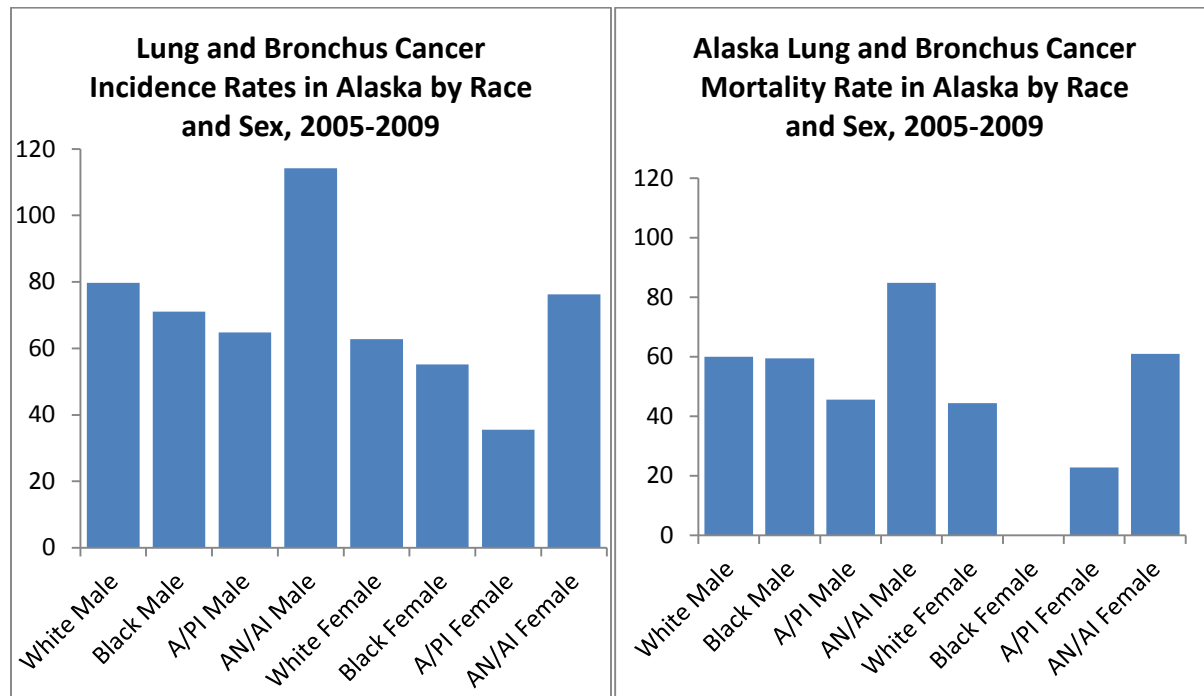
Smoking causes numerous cancers, including those of the bladder, cervix, esophagus, kidney, larynx, pancreas, and stomach, as well as leukemia and oral cancer.⁷ Lung cancer is the leading cause of cancer death in Alaska⁸, and smoking causes 80 to 90 percent of lung cancer cases.⁹

Alaska’s lung cancer mortality and incidence rates are declining, in line with national trends.¹⁰ This decline is correlated to decreased smoking rates in Alaska, with teen rates dropping from 37% in 1995 to 14% in 2011, and adult smoking rates declining from 27.7% in 1996 to 20.6% in 2010.¹¹ The amount of cigarettes smoked in Alaska has also dropped, with the number of packs purchased (per adult) declining from 128.6 packs in 1996 to 62.7 packs in 2010.¹² Despite the declines in teen and adult smoking rates, the percentage of young adults age 18-29 who identify as smokers has remained consistent between 1996-2010 at disproportionately high rates (31.7% of 18-29 year olds identifying as smokers in 2010).¹³

Geographic, socioeconomic, and racial disparities in tobacco use and cancer burden exist in Alaska. According to the Alaska Tobacco Facts 2012 update, Alaska Native adults, Alaskans of lower income, Alaskans with less education, and individuals living in rural areas of Alaska are all more likely to smoke.¹⁴

The smoking rate of Alaska Native adults has remained relatively consistent from 1996-2010, with 41% of adults identifying as smokers in 2010.¹⁵ This could contribute to the disproportionately high lung and bronchus cancer incidence and mortality rates of Alaska Native/American Indian people in Alaska:

Figure 1. Alaska Lung and Bronchus Cancer Incidence and Mortality Rates by Race and Sex per 100,000, 2005-2009¹⁶



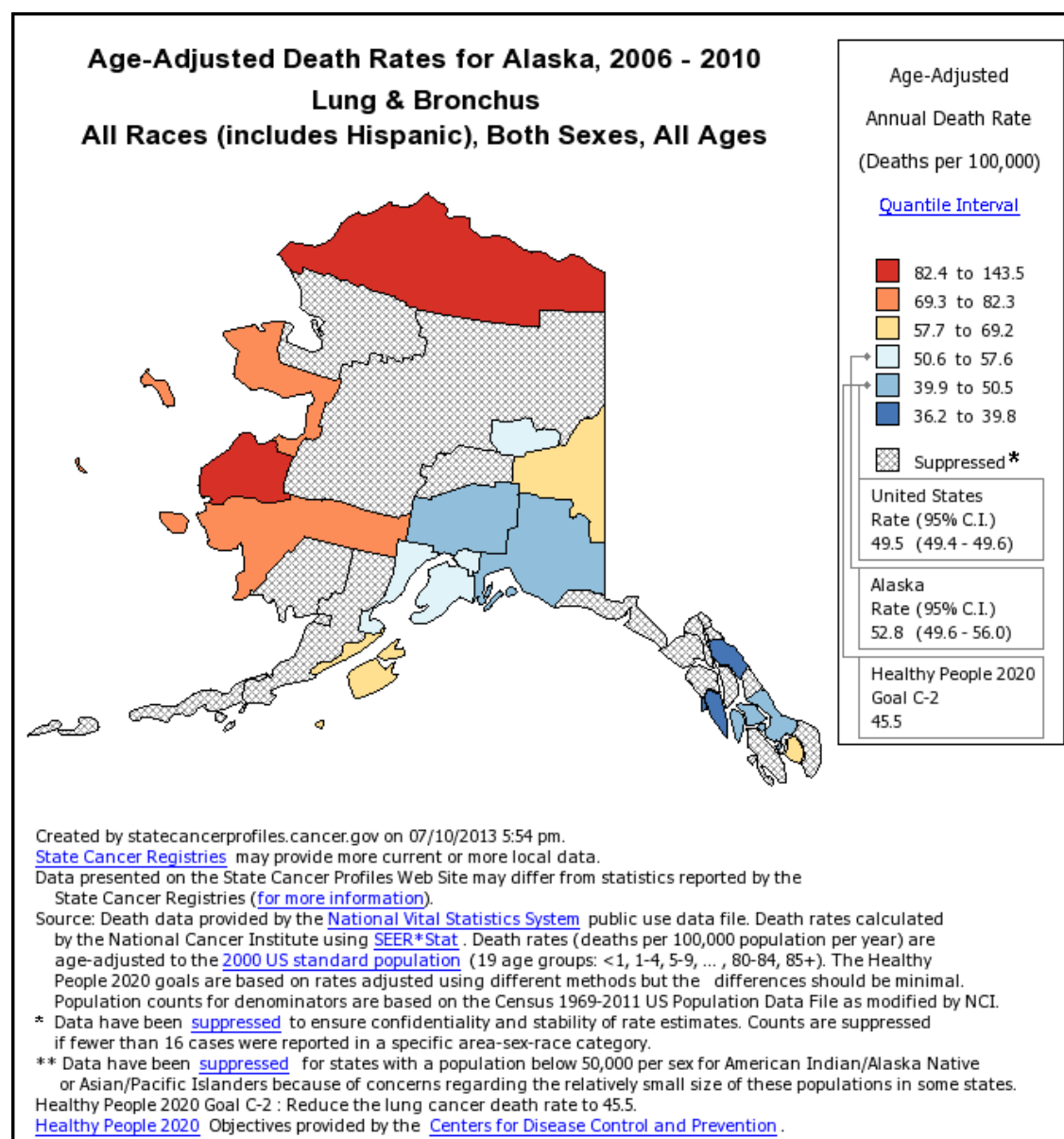
As shown in Figure 1, Alaska Native/American Indian (AN/AI) males suffered a cancer incidence rate of 114.2/100,000 population from 2005-2009 data, far exceeding the 79.7 rate of White males, 71.1 of Black males, and 64.8 of Asian/Pacific Islander (A/Pi) males. Female incidence rates of lung and bronchus cancer were generally lower than male incidence rates. However, AN/AI females were also disproportionately impacted with an incidence rate of 76.3, as compared to incidence rates of 62.8 (White females), 55.2 (Black females), and 35.5 (A/Pi females). Cancer mortality rates also disproportionately impacted AN/AI men and women. Geographic disparities in smoking rates exist in Alaska as well:

Table 1. Percentage of Alaskan Adults who Smoke, by Region, 2010¹⁷

Region	Percentage
North/NW/Interior	39%
Southwest	31%
Mat-Su Borough	26%
Southeast	22%
Fairbanks (North Star)	18%
Gulf Coast	16%
Municipality of Anchorage	17%
All Adults	21%

Alaskan adults in the North, Northwest, and Interior regions of Alaska reported the highest percentages of adults who smoked in 2010 at 39%, while the Gulf Coast, Anchorage, and Fairbanks regions reported the lowest percentages of smoking adults, at 16%, 17%, and 18% respectively (see Table 1). These geographic differences in smoking rates, as well as the disparities in population groups impacted by smoking, could contribute to the disproportionately high lung and bronchus cancer mortality rates in the North Slope Borough, North West, and Interior regions of Alaska:

Figure 2. Lung and Bronchus Cancer Mortality Rates in Alaska
Age-Adjusted Rates per 100,000, 2006-2010, All Races, Both Sexes, All Ages¹⁸



Although data isn't available for all regions of Alaska in Figure 3, from 2006-2010 data, lung and bronchus cancer mortality was disproportionately high in the North Slope

Borough, Nome Census Area, Wade Hampton Census Area, and Bethel Census Area, and relatively low in reported areas of Southcentral and Southeast Alaska.

Despite these disparities, several policy and environmental/systems changes have been recommended by national governmental organizations and their affiliates. Some of these environmental or policy level strategies have been implemented in Alaska, while the absence of implementation of some recommended strategies reveals gaps for potential improvement.

Table 2. Strategies on Tobacco Use in Alaska^{19,20}		
Recommended Policy or Environmental/Systems Change	Source of Recommendation	What's Happening in Alaska?
<u>Increasing the Unit Price of Tobacco Products</u> Evidence-Based Pricing Strategies to Discourage Tobacco Use Ban Free Samples and Price Discounts	The Community Guide CDC CDC	Minimum price law for cigarettes. ²¹ As of 1 st quarter 2013, Alaska had a \$2.00 cigarette tax per pack, 75% tax on wholesale price of smokeless tobacco, and no provisions on tax of chewing tobacco or snuff. ²² Alaska allowed local regulation of tobacco sampling as of June 30, 2012. ²³
<u>Mass Media Health Communication Interventions</u> Hard-Hitting Counter-Advertising	The Community Guide CDC	Alaska Tobacco Prevention and Control Alliance (TPC) hosted several media campaigns, but anti-tobacco media campaign levels were reported as below recommended levels. ²⁴
Ban Brand-Name Sponsorship Ban Branded Promotional Items and Prizes Restrict Point of Purchase Advertising Restrict Point of Purchase Product Placement	CDC	Alaska allowed local regulation of tobacco promotion, sampling, and display as of June 30, 2012, no preemptive state advertising laws as of 1 st quarter 2013. ^{25, 26}
<u>Provider Reminders when Used Alone</u> , to identify patients who use tobacco and prompt providers to discuss and advise	The Community Guide	In August 2011, the TPC issued a two year outreach and technical assistance contract to conduct outreach and offer free tobacco-related materials and technical assistance to organizations interested in implementing the USPHS Clinical Practice Guidelines (provider reminders are a strategy of the USPHS Clinical Practice Guidelines).

Table 2. Strategies on Tobacco Use in Alaska^{19,20}		
Recommended Policy or Environmental/Systems Change	Source of Recommendation	What's Happening in Alaska?
<u>Provider Reminders with Provider Education</u> , including provider reminder system and a provider education program	The Community Guide	The Alaska Tobacco Prevention and Control Program launched a web-based training "The Brief Tobacco Intervention: Helping Alaskan's Quit" for health care providers in June 2010 that is accredited by the American Academy of Family Physicians (AAFP). ²⁷
<u>Quitline Interventions</u> <u>Mobile Phone-Based Cessation Interventions</u> , usually through text messaging Quitline and other cessation services	The Community Guide The Community Guide CDC	Alaska's Tobacco Quit Line provides free phone based counseling to Alaskans, including motivational and appointment reminder text messages to Quit Line participants, and reached an estimated 2% of Alaska's tobacco users in 2010. ^{28, 29, 30} SmokefreeTXT is a national smoking cessation text messaging service designed for young adults. ³¹
<u>Reducing Out-of-Pocket Costs for Evidence-Based Tobacco Cessation Treatments</u>	The Community Guide	As of 2010, Alaska Medicaid covered some nicotine replacement therapies, smoking cessation medications Varenicline ³² and Bupropin ³³ , and individual counseling, but not group counseling. ³⁴
<u>Smoke-Free Policies</u> Usage Bans (100% smoke-free policies, 100% tobacco-free policies, tobacco-free school campuses) Zoning Restrictions	The Community Guide CDC CDC	100% smokefree ban in commercial day care. ³⁵ Smoking restricted to designated areas in government worksites, restaurants, and home-based day care centers. ³⁶ No smoking restrictions in private worksites. ³⁷

Table 2. Strategies on Tobacco Use in Alaska^{19,20}		
Recommended Policy or Environmental/Systems Change	Source of Recommendation	What's Happening in Alaska?
Restrict Sales (i.e. internet, to minors)	CDC	Minimum age for purchase of cigarettes is 19, possession by minor is prohibited, no provisions on purchasing or use, as of 1 st quarter 2013. ³⁸
Ban Self-Service Displays and Vending	CDC	Legislation enacted on restricted access, supervision, and location bans for vending machines, as of 1 st quarter 2013. ³⁹ No provisions on limiting the placement of vending machines or including locking devices, as of 1 st quarter 2013. ⁴⁰ Licensure required for vending machines that included cigarettes, but no provision existed for included chewing tobacco, as of 1 st quarter 2013. ⁴¹ Alaska allowed local regulation of displays as of June 30, 2012. ⁴²
<u>Community Mobilization with Additional Interventions to Restrict Minors' Access to Tobacco Products</u> , to focus attention on youth access to tobacco and mobilize community support to reduce that access.	The Community Guide	Alaska Tobacco Control Alliance Youth Workgroup coordinates communication with youth networks. ⁴³ The Tobacco Enforcement and Youth Education Program works to decrease youth access to tobacco by working with businesses and community organizations and enforcing compliance with existing laws. ⁴⁴
<u>Assessment of Health Risks with Feedback (AHRF) Plus Health Education with or without Other Interventions</u> , including an assessment of personal health habits and risk factors, assessment of future adverse health effects, and feedback to describe the impact of behavioral change	The Community Guide	No known state or federal policies

As of the 1st quarter of 2013, Alaska had a \$2.00 cigarette tax per pack,⁴⁵ as well as an excise tax on non-cigarette tobacco products set at 75% of the wholesale price, in addition to regional mark-ups.⁴⁶ The range of per pack excise taxes across the nation ranged from \$0.07 to \$3.46 per pack as of Dec. 31, 2009.⁴⁷

For anti-tobacco media campaigns, CDC Best Practices recommends an average quarterly exposure of 1,200 general audience gross rating points and 800 youth target rating points

in anti-tobacco media campaigns.⁴⁸ In 2010, Alaska had an average of 1,017.2 general audience gross rating points and 200.7 youth target rating points each quarter, which are below the recommended levels.⁴⁹

Physical Activity

Being overweight or obese is associated with an increased risk of cancers of the esophagus, pancreas, colon and rectum, breast (post-menopausal), endometrium, kidney, and thyroid.⁵⁰ In adults, overweight is defined as a BMI between 25 and 29.9 while obesity is considered a BMI of 30 or over.⁵¹ Evidence of the association between overweight and obesity and additional cancers is increasing, with evidence mounting for an increased risk of cancers of the gallbladder, ovary and liver.⁵² According to a 2010 article in *The Oncologist*, approximately 20% of all cancer cases are accounted for by weight, weight gain, and obesity.⁵³ Eating too many calories and not getting enough physical activity causes an energy imbalance that leads to overweight and obesity.⁵⁴ In addition to its association with overweight and obesity, physical activity is also independently associated with a reduced risk of colon and breast cancer, while potentially associated with a reduced risk of prostate, lung, and endometrial cancer.⁵⁵

As of 2010, 41.1% of Alaskan adults were overweight and 24.5% were obese.⁵⁶ 22.4% of adults reported not participating in any physical activity during the past month, while 72.5% reported consuming less than three vegetables a day and 69.2% reported consuming less than two fruits a day.⁵⁷ Alaska's adolescents reported less vegetable consumption, with 86.8% eating less than three servings of vegetables a day, and 72.5% reporting eating less than two servings of fruit or 100% fruit juice a day.⁵⁸

Identifying policies that effectively promote physical activity is an ongoing process, with initiatives such as the CDC-funded Physical Activity Policy Research Network⁵⁹ actively researching best practices. The key physical activity program efforts of the State of Alaska Obesity Prevention and Control Program (OPCP) are a social marketing campaign called "Play Every Day" and a partnership with Healthy Futures.⁶⁰ In addition to supporting community physical activity events and working with physically active Alaskan role models, Healthy Futures works to build the habit of daily physical activity by incentivizing Alaska's elementary school students to complete physical activity tracking logs for four weeks that document at least 30 min. of physical activity 3x a week (about 15% of Alaska's elementary school students participated in Spring 2013).^{61, 62}

Table 3. Strategies on Physical Activity in Alaska^{63, 64}

Policy or Environmental Strategy	Source	What's Happening in Alaska?
<u>Community-Wide Campaigns</u> that involve many community sectors and include highly visible, broad-based, multicomponent strategies such as social support, risk factor screening, or health education	The Community Guide	OPCP Social Marketing Campaign: <u>"Play Everyday"</u>
<ul style="list-style-type: none"> • <u>Enhanced School-Based Physical Education</u> that increases the amount of time students spend in moderate to vigorous activity in PE classes by making classes longer or increasing activity during class • Require Daily Quality Physical Education in Schools • Require Daily Activity in Afterschool/Childcare Settings 	<p>The Community Guide</p> <p>CDC CDC</p>	Voluntary physical education standards adopted by the State Board of Education in 2010, ⁵⁶ Alaska OPCP educated teachers on the standards in 2012, including the provision of evidence-based curriculum and training. ^{65, 66}
<ul style="list-style-type: none"> • <u>Community-Scale Urban Design and Land Use Policies</u> • <u>Street-Scale Urban Design and Land Use Policies</u> • City Planning, Zoning and Transportation, including sidewalks, parks, and Health Impact Assessments 	<p>The Community Guide</p> <p>The Community Guide</p> <p>CDC</p>	SB 46, enacted in 2011 (see below table for details)
<ul style="list-style-type: none"> • <u>Access to Places for Physical Activity Combined with Informational Outreach Activities</u> • Safe, Attractive, Accessible Places for Activity 	<p>The Community Guide</p> <p>CDC</p>	HB 307, enacted in 2005 (see below table for details)
<ul style="list-style-type: none"> • Promote Active Transportation for Commuting and Leisure Activities • Safe Routes to School 	<p>CDC</p> <p>CDC</p>	SB 46, enacted in 2011 SB 75, enacted in 2009 SB 327, enacted in 2003 HB 57, introduced in 2011 HB 132, introduced in 2011 (see below table for details)
<ul style="list-style-type: none"> • <u>Point of Decision Prompts to Encourage Use of Stairs</u> • Signage for Neighborhood Destinations in Walkable/Mixed-Use Areas • Signage for Public Transportation, Bike Lanes/Boulevards 	<p>The Community Guide</p> <p>CDC</p> <p>CDC</p>	No known state or federal policies
<ul style="list-style-type: none"> • <u>Behavioral Interventions to Reduce Screen Time</u> • Counter-Advertising For Screen Time • Restrict Screen Time 	<p>The Community Guide</p> <p>CDC CDC</p>	No known state or federal policies

Table 3. Strategies on Physical Activity in Alaska^{63, 64}		
Policy or Environmental Strategy	Source	What's Happening in Alaska?
<u>Worksite Programs</u> designed to improve health outcomes	The Community Guide	No known state or federal policies

Since 2001, Alaska has enacted eight policies or appropriations relating to physical activity, while two have been introduced and two are dead. Further research would be needed to determine their impact on levels of physical activity in Alaska.⁶⁷

- Enacted Policies:
 - 2011, SB 46, Appropriations for items including playgrounds, gyms, bike and pedestrian facilities, and pedestrian improvements.⁶⁸
 - 2010, Citation 4 AAC 04.140 modified language of physical education standards to include new lead-in language, and amended a subsection.⁶⁹ No changes that would impact physical activity were noted.
 - 2009, SB 75, Appropriations for items including pedestrian, trail, and bike improvements, as well as a new physical education shelter at an elementary school⁷⁰
 - 2009, HB 49, "Prohibits the exercise of power over eminent domain against a recreational structure for the purposes of developing a recreational facility or project⁷¹.
 - 2005, HB 42, Named a coastal trail
 - 2005, HB 307, Created the Knik Public Use Area
 - 2004, ENT 2003S, Appropriations for the Alaska Disabled Sports Program
 - 2003, SB 327, Allowed the use of wheeled methods of transportation, such as rollerblades, on streets and trails.⁷²
- Introduced Policies:
 - 2011, HB 57, Appropriations to allow sponsorship of a program to encourage bicycles as a mode of transportation, and amends the duties of the Department of Transportation and Public Facilities to administer funds for that purpose.⁷³
 - 2009, HB 132, Authorized the sponsorship of a program to encourage bicycles as a mode of transportation, amends the duties of the Department of Commerce, Community, and Economic Development to administer funds for that purpose, amends provisions allowing for funding allocated for highways to be used to support bicycle paths.⁷⁴
- Dead Policies:
 - 2009, HB 82, Appropriations including items for liability and indemnity and safe routes to schools.
 - 2009, HB 399, Established a Health Impact Assessment program at DHSS.

While many of the bills are multi-faceted and relate to several recommended areas of intervention, several of the bills are centered around biking as a mode of transportation, including the improvement of trails and bicycle/pedestrian facilities.

Nutrition

As summarized by the Scientific Support and Clinical Translation Team of the CDC's Comprehensive Cancer Control Branch, Media, Access, Point of decision information, Price, and Social support/services (MAPPS) interventions include policies around food/drink availability that are listed below:⁷⁵

Table 4. Strategies on Nutrition in Alaska.⁷⁶

Policy or Environmental Strategy	Source	What's Happening in Alaska?
Promotion		
Increase Healthy Food/Drink Availability, including incentives to food retailers to locate/offer healthier choices, healthier choices in schools, worksites, etc.	CDC	OPCP partnership with Alaska Department of Education and Early Childhood Development (DEED) to provide resources and training to school districts on salad bars. ⁷⁷
Promote Healthy Food/Drink Choices	CDC	SB 18, enacted in 2013 appropriates funding to the Nutritional Alaskan Foods in Schools program School districts that participated in federal school meal programs were required to develop wellness policies by 2006-2007 school year. ⁷⁸
Farm to Institution Programs	CDC	Alaska OCPD partnered with the Division of Agriculture to fund Farm to School projects. ⁷⁹
Support Breastfeeding Through Policy Change and Maternity Care Practices	CDC	HB 176 and SB 42, both introduced in 2009
Menu Labeling and Signage for Healthy/Unhealthy Items	CDC	No known state or federal policies
Food Procurement Policies to make healthier food more available, affordable, and appealing. ⁸⁰	CDC	HB 40, enacted in 2013 exempts certain farm structures from taxes
Restriction		
Limit Unhealthy Food/Drink Availability	CDC	No known state or federal policies
Reduce Density of Fast Food Establishments	CDC	No known state or federal policies
Eliminate Trans Fat Through Purchasing Actions, Labeling Initiatives, Restaurants Standards	CDC	No known state or federal policies

A key nutrition effort of the Alaska Obesity Prevention and Control Program (OPCP) is the Alaska Food Policy Council that works to improve the Alaskan food system.⁸¹ However the OPCP has partnered with a variety of organizations to support Farm to School programs, to promote traditional Alaska Native foods, to provide training and resources to schools on salad bars, and to assist Farmer's markets in accepting Electronic Benefits Transfer (EBT) from individuals receiving nutrition assistance from the Supplemental Nutrition Assistance Program (SNAP) and educating SNAP recipients that their cards can be used at Farmer's Markets.⁸²

Since 2001, Alaska has enacted seven policies or appropriations related to nutrition, while two have been introduced and one died in the House, but was passed in the Senate.⁸³ Further research would be needed on all policies to determine their impact on nutrition in Alaska.

- Enacted Policies:
 - 2013, HB 40, Allows municipalities to exempt specific farm structures from taxes.⁸⁴
 - 2013, SB 18, Appropriates 3 million dollars to the Nutritional Alaskan Foods in Schools program to reimburse school districts for the purchase of Alaskan harvested foods.⁸⁵
 - 2010, HB 70, Appropriation to establish the farm-to-school program in the Department of Natural Resources, to be repealed July 1, 2013.
 - 2010, HB 175, Appropriations for items including exempting rewards from a wellness program as insurance discrimination or rebating.
 - 2007, ENT2007S, Appropriates funds to a correctional facilities farm program.
 - 2005, HB 307, Appropriation to create the Knik River Public Use Area to promote the traditional public use of fish and wildlife.
 - 2003, ENT2003H, Appropriates funds to a correctional facilities farm program.
- Introduced Policies:
 - 2009, HB 176, "An act relating to break times for employees who nurse a child".⁸⁶
 - 2009, SB 42, "An act relating to break times for employees who nurse a child".⁸⁷ Same text as HB 176.
- Dead Policies:
 - 2007, ENT2007H, Appropriates funds to a correctional facilities farm program.

None of the policies enacted in Alaska since 2001 strive to limit unhealthy food/drink availability statewide, although there are organizational or regional policies, such as the Anchorage School District wellness policy that effectively bans soda and junk food in schools.⁸⁸ Alaska has enacted two appropriations for a correctional facilities farm program, and one appropriation to establish the farm to school program. However, no statewide policies have been introduced or enacted since 2001 on menu labeling/signage, procurement policies and practices, or increasing the placement and attractiveness of healthy products.

Sun Safety/Reducing UV Exposure

While there are no known policies to reduce UV exposure in Alaska, skin cancer rates are relatively low in the state. From 1996-2004 data, melanoma of the skin accounted for

approximately 3% of the cancers diagnosed in Alaska, and about 0% of cancer mortality in the state.⁸⁹ However, as of July 2012, 34 states had enacted laws banning minors from indoor tanning facilities or requiring parental permission.⁹⁰ However, an evaluation of 28 states that had passed legislation for indoor tanning facilities in 2008 found relatively low enforcement (low rates of annual inspections and citations), and no known research is available evaluating a correlation between the legislation and skin cancer rates.⁹¹

Table 5. Strategies on UV Exposure in Alaska⁹²

Policy or Environmental Strategy	Source	What's Happening in Alaska?
<i>Education and Policy Approaches</i>		
<u>Primary and Middle School Interventions</u> , including policies on clothing guidelines and restrictions on outdoor activities during peak sunlight hours	The Community Guide	No known state or federal policies
<u>Outdoor Recreation Settings</u> , including provision of sunscreen and point of purchase prompts	The Community Guide	No known state or federal policies
<i>Community-Wide interventions</i>		
<u>Multicomponent Community-Wide Interventions</u> , including combinations of individual strategies, mass media campaigns, and environmental and policy changes	The Community Guide	No known state or federal policies
"The strength of the existing evidence suggests that policymakers should consider enacting measures, such as prohibiting minors and discouraging young adults from using indoor tanning facilities..." ⁹³ "Our highest regulatory priority should be the restriction of use by persons under 18 years as well as banning unsupervised trained personnel." ⁹⁴	World Health Organization International Agency for Research on Cancer	No known state-wide restrictions as of July 2012 ⁹⁵

Use of Vaccines to Prevent Cancer

Cervical cancer and some types of liver cancer can be prevented by vaccinations. Some strains of the Human Papilloma Virus (HPV) cause cervical cancer.⁹⁶ While there are about 40 different strains of HPV, the vaccine prevents against the most common types leading to cervical cancer and genital warts.⁹⁶ The vaccine is effective for females and males aged 9 through 26, and recommended to be administered to girls and boys ages 11 or 12, or to women aged 26 and younger and men aged 21 and under who didn't receive the vaccine when they were younger.⁹⁶ The Hepatitis B virus causes some cancers of the liver, and vaccination to prevent infection is recommended for all ages.⁹⁷

Table 6. Strategies On Vaccinations to Prevent Cancer in Alaska. ⁹⁸		
Policy or Environmental Strategy	Source	What's Happening in Alaska?
<i>Enhancing Access to Vaccination Services</i>		
<u>Reducing Out-of-Pocket Costs</u>	The Community Guide	State-supplied hepatitis B and HPV vaccines available for Vaccines for Children (VFC)-eligible, and underinsured children. As of Dec. 31, 2012, fully insured children were no longer eligible for state-supplied vaccines. ⁹⁹
<u>Vaccination Programs in Schools and Organized Child Care Centers</u>	The Community Guide	No known state or federal policies
<u>Vaccination Programs in WIC Settings</u>	The Community Guide	No known state or federal policies
<i>Increasing Community Demand for Vaccinations</i>		
<u>Client or Family Incentive Rewards</u> , including monetary and nonmonetary incentives given to clients or families to get recommended vaccinations.	The Community Guide	No known state or federal policies
<u>Client Reminder and Recall Systems</u> , including telephone calls, letters, or postcards to target individuals.	The Community Guide	No known state or federal policies
<u>Community-Based Interventions Implemented in Combination</u> , including client reminder and recall systems, mass media, small media, education, expanded access, etc.	The Community Guide	See “Reducing Out-of-Pocket Costs” for access to HPV and Hepatitis B vaccines.
<u>Vaccination Requirements for Child Care, School, and College Attendance</u>	The Community Guide	HPV vaccine not required for school/child care attendance ¹⁰⁰ Hepatitis B vaccination required for children entering pre-elementary through 12 th grade at a state public school district or nonpublic school. ¹⁰¹
<i>Provider or Systems Based Interventions</i>		
<u>Health Care System-Based Interventions Implemented in Combination</u> of two or more coordinated interventions	The Community Guide	No known state or federal policies

Table 6. Strategies On Vaccinations to Prevent Cancer in Alaska.⁹⁸		
Policy or Environmental Strategy	Source	What's Happening in Alaska?
<u>Immunization Information Systems</u>	The Community Guide	Alaska's immunization information system, "VacTrAK", went live in April 2008. ¹⁰²
<u>Provider Assessment and Feedback</u>	The Community Guide	No known state or federal policies
<u>Provider Reminders</u>	The Community Guide	No known state or federal policies
<u>Standing Orders When Used Alone</u> , allowing healthcare personnel to assess an individual's vaccination status and administer vaccinations according to a protocol, without an examination or direct order from an attending provider.	The Community Guide	No immunization specific language in relevant Alaska laws. ¹⁰³ Physician Assistants can engage in immunization assessment, prescription, and administration of medications under standing orders, but not pharmacists or nurses. ¹⁰⁰

Radon Exposure

Radon is estimated to be the second leading cause of lung cancer, contributing to about 15,000 to 22,000 cancer deaths each year in the U.S.¹⁰⁴ However, radon was established as a risk factor for lung cancer as late as 2006 with a report by the World Health Organization's International Radon Project, consequently policy recommendations are still being developed.¹⁰⁵

Table 7. Strategies on Radon Exposure in Alaska.^{106, 107}		
Policy or Environmental Strategy	Source	What's Happening in Alaska?
Test all homes for radon Conduct Testing and Perform Mitigation When Necessary	Environmental Protection Agency Federal Radon Action Plan	Federal Radon Action Plan: HUD wrote new radon testing and mitigation requirements for some multifamily housing mortgage insurance programs. ¹⁰⁸
Create Radon-Resistant New Home Construction Codes	Environmental Protection Agency	Alaska does not have statewide or local radon-resistant new construction codes, as of Aug. 15, 2012. ¹⁰⁹

Table 7. Strategies on Radon Exposure in Alaska.^{106, 107}

Policy or Environmental Strategy	Source	What's Happening in Alaska?
Provide Incentives to Encourage Testing and Mitigation	Federal Radon Action Plan	Federal Radon Action Plan: HUDs PowerSaver Loan Program allows for radon mitigation expenses. ¹¹⁰
Demonstrate the Importance of Radon Testing and Mitigation	Federal Radon Action Plan	Federal Radon Action Plan promoting awareness of radon, including the inclusion of radon on state cancer plans. ¹¹¹

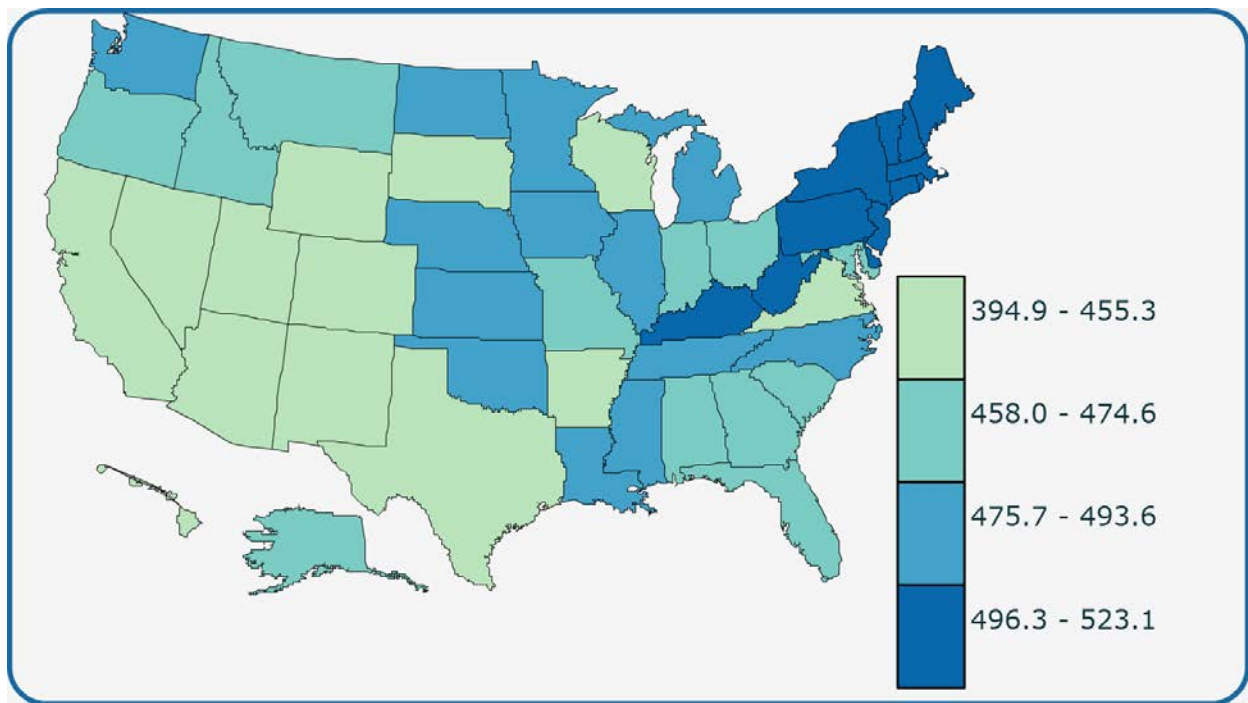
Detection and Diagnosis: Screening

Some cancers can be detected early through the use of screenings, and cancer treatment is generally more effective when a cancer is found earlier.¹¹² Colorectal and cervical cancer can also be prevented through the use of screening. Regular screenings reduce cancer deaths from breast, cervical, colorectal, and lung cancer, although the ability to reduce deaths from prostate cancer, or other types of cancer, through screenings hasn't been clearly established.¹¹³ Consequently, this section will focus on screenings to prevent and detect lung, breast, cervical, colorectal, and lung cancer.

Cancer Incidence

Alaska's all cancer incidence rate from 2005-2009 data was 474.6 per 100,000 (ranked 25th out of 51 states + District of Columbia).¹¹⁴

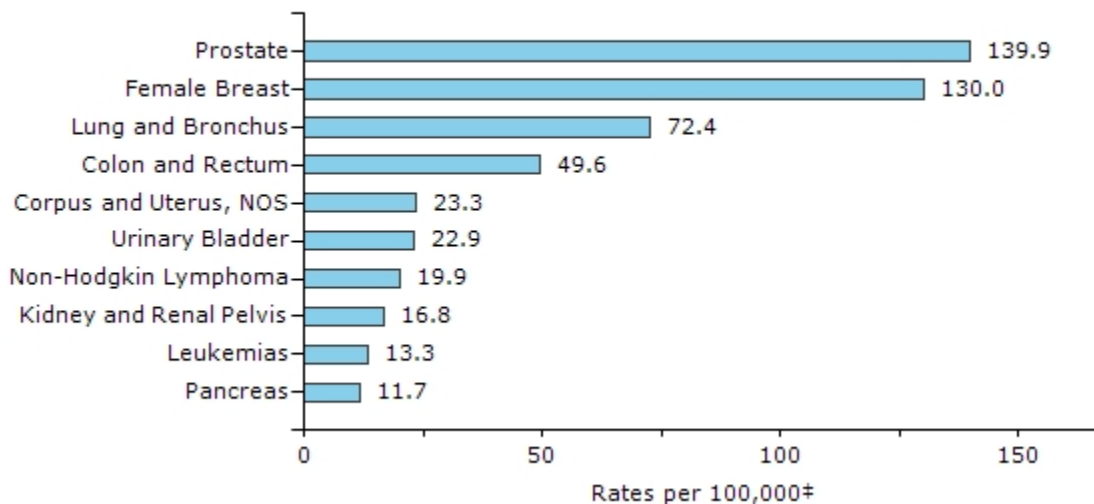
**Figure 3. Age-Adjusted Cancer Incidence Rates
per 100,000 by State, 2005-2009¹¹⁵**



When looking at cancer incidence rates of all cancer sites, all races, and male and female in Figure 3, in general, northeastern states had higher cancer incidence rates than the rest of the country, while states in the southwest had lower cancer incidence rates. Arizona reported the lowest incidence of cancer with a rate of 394.9 per 100,000 population, while Kentucky recorded the highest incidence of cancer with a rate of 523.1.

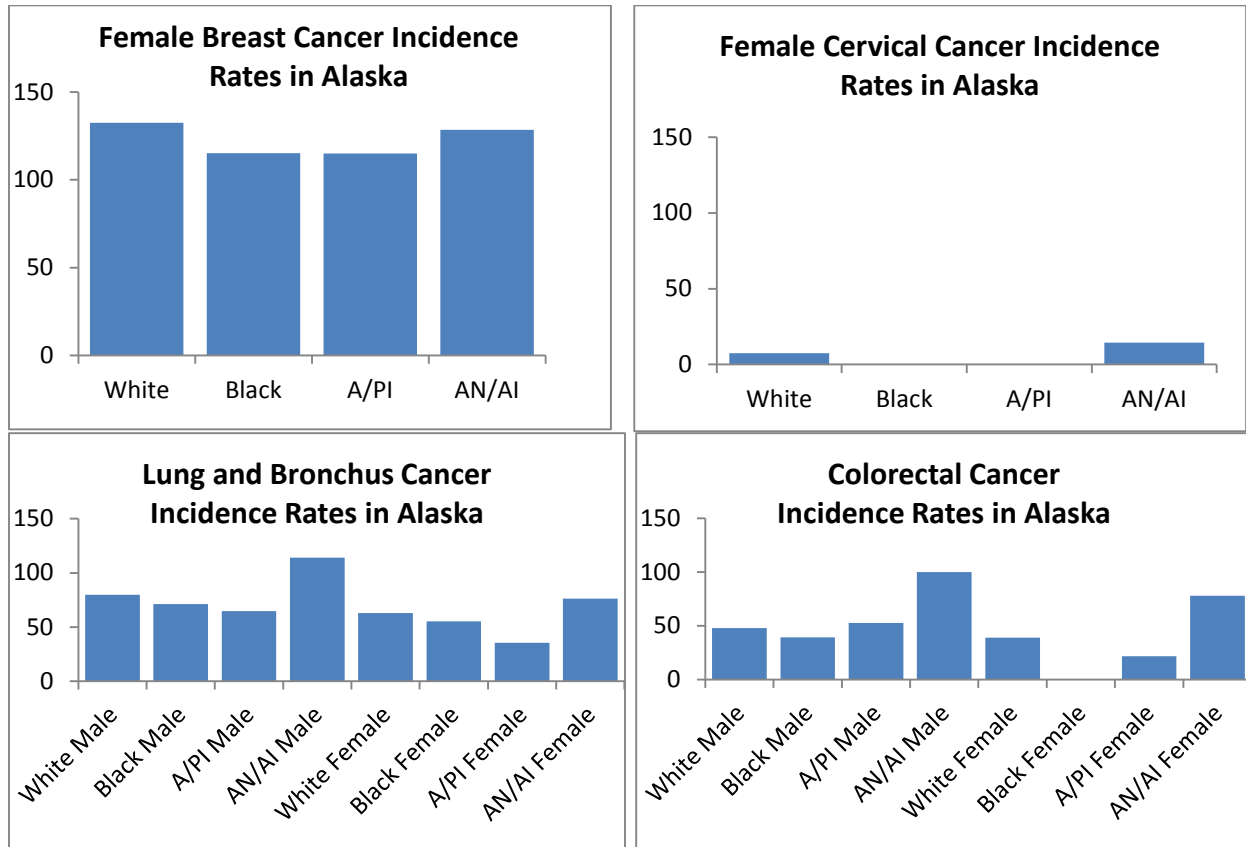
Figure 4. Alaska Cancer Incidence Rates by Cancer Site
Age-Adjusted Invasive Rates per 100,000 ¹¹⁶

Top 10 Cancer Sites: 2005-2009, Male and Female, Alaska—All Races



As shown in Figure 4, the top ten cancer sites by incidence rates of all races and male and female were prostate (139.9 per 100,000 population), female breast (130.0), lung and bronchus (72.4), colon and rectum (49.6, corpus and uterus (23.3), urinary bladder (22.9), non-hodgkin lymphoma (19.9), kidney and renal pelvis (16.8), leukemias (13.3), and pancreas (11.7). Comparing incidence rates of the top four cancers (prostate, female breast, lung and bronchus, and colorectal cancer) to incidence rates in the US between 2005-2009, Alaska has one of the lowest incidences of prostate cancer (ranking 9 out of 51 with a rate of 139.9).¹¹⁷ However, Alaska has a moderately high incidence rate for cancer of the lung and bronchus (36 out of 51, with a rate of 72.4), and has one of the highest incidences of female breast cancer (44th out of 51 with a rate of 130.0), and colorectal cancer (42nd out of 51 with a rate of 49.6).¹¹⁸ Cervical cancer incidence in Alaska was 8.7 per 100,000 from 2005-2009 data, ranking 38th out of 51 when compared nationally.¹¹⁹

Figure 5. Alaska Incidence Rates of Breast, Cervical, Lung, and Colorectal Cancer by Race and Sex per 100,000, 2005-2009.¹²⁰



Between 2005-2009, female breast cancer had the highest incidence rates for Alaskan women across all racial groups.¹²¹ White women had the highest incidence rates of female breast cancer at 132.4 per 100,000 population, as compared to 128.4 among Alaska Native/American Indian (AN/AI) women, 115.1 among Black women, and 115 among Asian/Pacific Islander (A/PI) women (see Figure 5). Alaska Native/American Indian men and/or women had higher rates of colorectal cancer, cervical cancer, and lung cancer than any other racial group.¹²²

Detection and Diagnosis of Lung Cancer

Based on the National Cancer Institute's (NCI) National Lung Screening Trial, NCI recommends screening among persons aged 55-74 years who have at least 30 pack-years of smoking history, and are either current smokers or have quit within the last 15 years.¹²³ The National Lung Screening Trial found up to a 20% decrease in mortality among high risk individuals who were screened for lung cancer by low-dose helical computed tomography.¹²³

The National Lung Association recommends that “Hospitals and screening centers should establish ethical policies for advertising and promoting lung cancer CT screening services,” although no known state or federal policies are implemented in line with this recommendation.¹²⁴ As the recommendation for lung cancer screening is relatively new, no known specific state or national policy recommendations from national governmental organizations exist for the screening, the use of the screening, or the accessibility of the screening to Alaskans. However, despite the lack of national recommendations, Alaska and other states are moving towards increasing accessibility of lung cancer screenings; as of June 4, 2013, the State of Connecticut General Assembly was debating Senate Bill 862 “An Act requiring Health Insurance Coverage for Lung Cancer Screening,”¹²⁵ and lung cancer screening was available in at least one hospital in Alaska as of May 2013¹²⁶

Table 8. Strategies On Breast, Cervical, and Colorectal Cancer Screenings¹²⁷		
Policy or Environmental Strategy	Source	What’s Happening in Alaska?
<u>Provider Assessment and Feedback</u>	The Community Guide (for breast, cervical, and colorectal cancer)	No known state or federal policies
<u>Provider Reminder System</u>	The Community Guide (for breast, cervical, and colorectal cancer)	No known state or federal policies
<u>Client Reminders</u>	The Community Guide (for breast, cervical, and colorectal cancer)	No known state or federal policies
<u>Small Media</u> , including letters brochures or newsletters to inform and motivate people to get screened for cancer.	The Community Guide (for breast, cervical, and colorectal cancer)	No known state or federal policies
<u>Group Education</u> usually conducted by either a health professional or trained layperson to inform, encourage, and motivate participants to get recommended screenings	The Community Guide (for breast cancer. Insufficient evidence for cervical, and colorectal cancer)	No known state or federal policies
<u>One-on-One Education</u> conducted in person or via phone in a variety of settings	The Community Guide (for breast, cervical, and colorectal cancer)	No known state or federal policies
<u>Reducing Structural Barriers for Clients</u> , including non-economic burdens such as hours of service, time and distance to service, administrative procedures, etc.	The Community Guide (for breast and colorectal cancer. Insufficient evidence for cervical cancer)	No known state or federal policies

Table 8. Strategies On Breast, Cervical, and Colorectal Cancer Screenings ¹²⁷		
Policy or Environmental Strategy	Source	What's Happening in Alaska?
<u>Reducing Client Out-of-Pocket Costs</u>	The Community Guide (for breast cancer. Insufficient evidence for cervical and colorectal cancer)	<p>Alaska Breast and Cervical Cancer Health Check program (BCHC) covers breast and cervical cancer screenings for eligible women (low-income, without insurance, etc.)¹²⁸</p> <p>Alaska Statute 21.42.375 mandates insurance coverage for recommended breast cancer screening, and Alaska Statute 21.42.395 mandates insurance coverage for recommended cervical cancer screenings.¹²⁹</p> <p>Both the Affordable Care Act (ACA), and Alaska state law require full insurance coverage of colorectal cancer screenings.¹³⁰</p> <p>CDC's Colorectal Cancer Control Program (CRCCP) has provided funding to the Arctic Slope Native Association, Alaska Native Epidemiology Center, and Southcentral Foundation to increase colon cancer screening rates.¹³¹</p>

Treatment

The National Cancer Institute estimates that approximately 1,660,290 men and women will be diagnosed with cancer in 2013.¹³² The treatment and prognosis (forecast of disease outcome) for cancer diagnoses depends on the stage at diagnosis, the biological characteristics of the tumor, the type of cancer, and the age and health of the patient. Unlike other steps along the continuum, there is less clarity regarding specific

recommendations from the national level. This is largely due to the uniqueness of each patient's circumstances. Doctors usually tailor their approach to each specific case. However, there are agreed upon steps in these processes and some states have been more aggressive than others in mandating insurance coverage for cancer treatment, raising revenues, expanding coverage, and adopting newly accepted methods.

Commission on Cancer Accreditation (CoC)¹³³

In an effort to identify best practices and standards we have examined the Commission on Cancer's standards for accredited facilities. The Commission on Cancer (CoC) is a part of the American College of Surgeons (ACoS).¹³⁴ The ACoS "is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard-setting, prevention, research, education, and the monitoring of comprehensive quality care."¹³⁵ The CoC Accreditation Program "encourages hospitals, treatment centers, and other facilities to improve their quality of patient care through various cancer-related programs. These programs are concerned with the full continuum of cancer from prevention through hospice and end-of-life care or survivorship and quality of life."¹³⁶

CoC Accreditation¹ is granted only to the facilities that have voluntarily committed to provide the best in cancer diagnosis and *treatment* and are able to comply with established CoC standards². Each cancer program must undergo a rigorous evaluation and review of its performance and compliance with the CoC standards. To maintain accreditation, facilities with accredited cancer programs must undergo an on-site review every 3 years. Currently, Alaska has three hospitals that are fully accredited. Fairbanks Memorial Hospital has been continuously accredited since 1976³, Providence Alaska Medical Center has held its accreditation continuously since 2004, and Alaska Regional received accreditation in 2010⁴. According to the American College of Surgeons Cancer programs⁵, some of the benefits of accreditation include organized care, data analysis, and public awareness, as well as national recognition by an organization such as the National Cancer Institute. From the patient and community's standpoint, accreditation ensures access to comprehensive care which includes prevention and early detection, information about ongoing clinical trials, and a multidisciplinary team approach.

¹ <http://www.facs.org/cancer/coc/programstandards2012.pdf>

According to the Cancer Program Standards, The Commission on Cancer consists of a number of professional organizations dedicated to improving survival and quality of life for cancer patients. The American College of Surgeons established the Commission on Cancer in the 1922. At its inception, it was known as the Committee on Treatment for Malignant Diseases.

² See Appendix I for detailed information on the Commission on Cancer Accreditation Standards.

³ Fairbanks memorial has also been granted a three year accreditation by the National Accreditation Program for Breast Centers (NAPBC).

⁴ Alaska Regional Hospital and Fairbanks Memorial are Community Cancer Programs while Providence is a Comprehensive Community Cancer Program. Different Accreditation categories require different specifications in terms of compliance.

⁵ Benefits of Accreditation: <http://www.facs.org/cancer/coc/benefitsofcoc.html>

State Health Insurance Mandates

Treatment is not only dependent on the availability and quality of care, but also on the affordability of services and insurance coverage available to Alaska patients. A health insurance “mandate” is a requirement that an insurance company or health plan offer coverage for health care providers, benefits and patient populations.

States have required insurance coverage of certain health benefits and treatments since the 1960s. Early mandates guaranteed that the insured would receive a certain level of care and benefits under a given policy. More recently, advocates for specific diseases and conditions have lobbied legislatures to improve access and treatment for people with particular diseases. Cancer-related mandates began as requirements for treatments but now include screening and prevention efforts to expand access to life-saving services. The following table details treatment related health insurance mandates, however further research would be needed to determine whether providing such mandates is associated with better or worse treatment outcomes.

Table 9. Commission on Cancer Accreditation and Insurance Mandates for Coverage of Cancer Treatment^{6, 137}		
Policy or Environmental Strategy	Source	What’s Happening in Alaska? ¹³⁸
Commission on Cancer Accreditation	American College of Surgeons ¹³⁹ Cancer Programs, Hospital Locator.	Fairbanks Memorial Hospital has been continuously accredited since 1976 ⁷ , Providence Alaska Medical Center has held its accreditation continuously since 2004, and Alaska Regional received accreditation in 2010 ⁸ .
Insurance Mandate for Coverage of Ambulatory Cancer Treatment	National Conference of State Legislature ¹⁴⁰	No known state or federal policies
Insurance Mandate for Coverage of Bone Marrow Transplant	National Conference of State Legislature	No known state or federal policies

⁶ An alternative Source which contains the same information: Health Insurance Mandates in the States –2010: Council for Affordable Health Insurance. This report contains all insurance mandates and not just cancer related ones.

⁷ Fairbanks memorial has also been granted a three year accreditation by the National Accreditation Program for Breast Centers (NAPBC).

⁸ Alaska Regional Hospital and Fairbanks Memorial are Community Cancer Programs while Providence is a Comprehensive Community Cancer Program. Different Accreditation categories require different specifications in terms of compliance.

Table 9. Commission on Cancer Accreditation and Insurance Mandates for Coverage of Cancer Treatment^{6, 137}		
Policy or Environmental Strategy	Source	What's Happening in Alaska? ¹³⁸
Insurance Mandate for Coverage of Breast Reconstruction	National Conference of State Legislature	HB 303 ¹⁴¹ requires health care insurers that provide medical and surgical benefits for mastectomies to comply with 42 U.S.C. 300gg-6 and 42 U.S.C. 300gg-52 regarding coverage for reconstructive surgery following mastectomies.
Insurance Mandate for Coverage of Cancer Pain Medications ⁹	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Chemotherapy	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Clinical Trials	National Conference of State Legislature	Passed in 2010: SB 10, c. 117. The bill requires specified individual and group insurers, including health maintenance organizations and public employee health plans to cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders
Insurance Mandate for Coverage of Long Term Care ¹⁰	National Conference of State Legislature	No known state or federal policies

⁹ Such therapies include pain assessment and management, inpatient and outpatient referral to a pain specialist for assessment and treatment planning, short- and long-term multimodality treatments, and follow-up, including side-effect management. Therapies may include durable medical equipment to administer medicine therapies.

¹⁰ These include a broad range of supportive medical, personal and social support services needed by people who are unable to meet their basic living needs for an extended period of time. These supports can be offered at home or in an institution (e.g., nursing home). The insurance mandate provides for evaluation and care.

Table 9. Commission on Cancer Accreditation and Insurance Mandates for Coverage of Cancer Treatment^{6, 137}		
Policy or Environmental Strategy	Source	What's Happening in Alaska? ¹³⁸
Insurance Mandate for Coverage of Mastectomy	National Conference of State Legislature	No (According to two studies ¹⁴²).However: HB303 requires health care insurers that provide medical and surgical benefits for mastectomies comply with 42 U.S.C. 300gg-6 and 42 U.S.C. 300gg-52, both regarding coverage for reconstructive surgery following mastectomies. HB 65 ¹¹ and SB78 tackle some facets of this issue
Insurance Mandate for Coverage of Minimum Mastectomy Hospital Stay	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Minimum Hysterectomy Hospital Stay	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Minimum Testicular Cancer Hospital Stay	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Off-Label Drug Use	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of a Second Opinion – allowing patients to seek a second option regarding surgery options	National Conference of State Legislature	No known state or federal policies
Insurance Mandate for Coverage of Testicular Cancer Diagnosis and Treatment	National Conference of State Legislature	No known state or federal policies

¹¹ **HB65:** Subject to other Medicaid eligibility provisions stated elsewhere in the law, persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under U.S.C. 1396a (a) (10) (A) (ii) (XVIII) are eligible for medical assistance whenever they are eligible for such coverage, if they apply for the assistance before two years after the effective date of this act. **SB78:** Repeals and codifies, with amendment, the uncodified provisions related to Medicaid eligibility noted in Record No. 2911. Persons who have been diagnosed with breast or cervical cancer and who are eligible for coverage under 42 U.S.C. 1396a (a) (10) (A) (ii) (XVIII) are eligible for medical assistance. Persons who were eligible under the repealed provisions may continue receiving medical assistance without reapplying.

Clinical Trials:

According to the National Cancer Institute, “clinical trials are the primary vehicle for advancing the treatment, detection, and prevention of cancer. Participation is low, however, with only about 3 percent of adult patients taking part in clinical trials.”¹⁴³ Chum et al (2011) notes that the cost of participating in a clinical trial is considered to be a major barrier to patient enrollment.¹⁴⁴ In order to reduce the barrier, some states in the US have implemented policies requiring health insurers to cover routine care costs for patients enrolled in clinical trials. In addition, section 2709 of the Affordable Care Act outlines statutory language requiring insurance coverage of approved clinical trials. According to the State Cancer Legislative Database, Alaska enacted SB10, c.177 in 2010 that:

“requires specified individual and group insurers, including health maintenance organizations and public employee health plans (collectively, “insurers”) to cover routine patient care costs incurred by a patient enrolled in an approved clinical trial related to cancer, including leukemia, lymphoma, and bone marrow stem cell disorders. “Approved clinical trial” means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care of a subject, if the study is approved by: (1) an institutional review board that complies with federal law; and (2) one or more of the following: (a) the United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers; (b) the United States Food and Drug Administration (“FDA”); (c) the United States Department of Defense; (d) the United States Department of Veterans Affairs; or (e) a nongovernmental research entity abiding by current NIH guidelines”¹⁴⁵.

Oral Chemotherapy (Alaska is a non-participant):

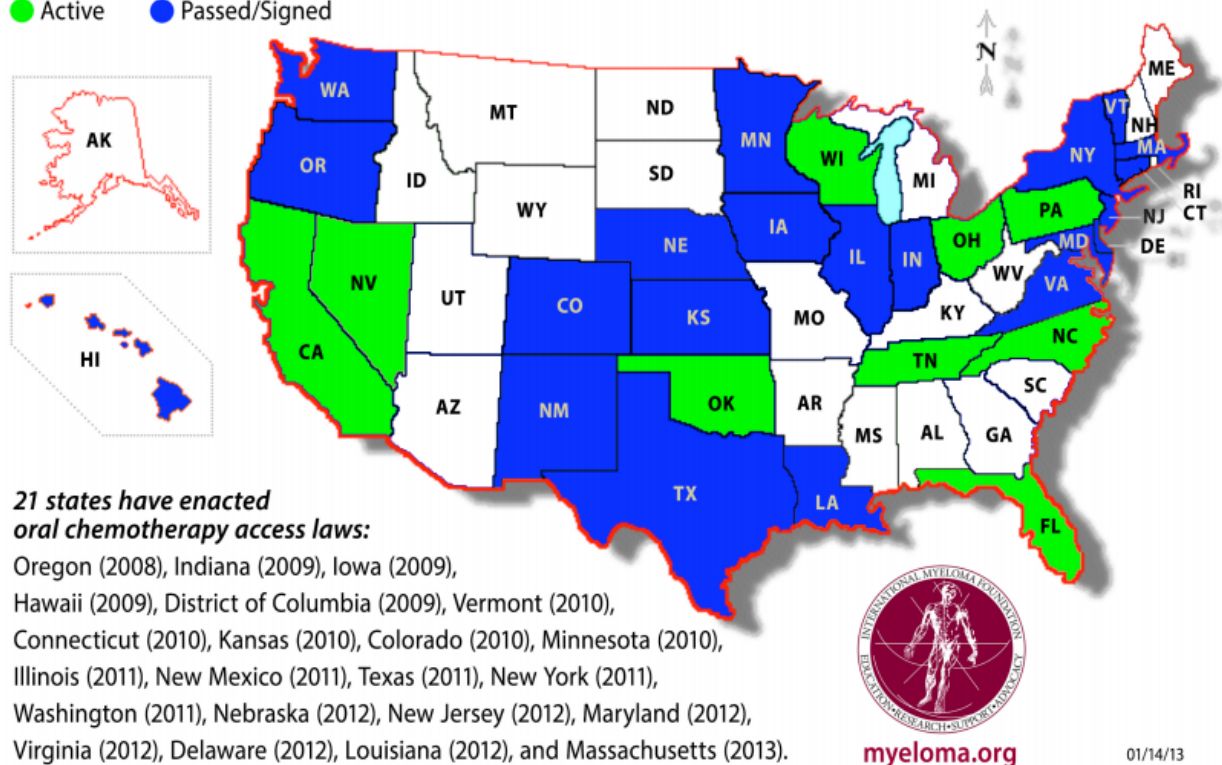
Orally administered chemotherapy represents¹⁴⁶ an increasing share of chemotherapy administered to cancer patients. Oral chemotherapy access and parity is supposed to reduce the trade-off between best treatment and financial stability. It also allows different cancers to be treated similarly given that some of forms of cancers (blood cancers) are more reliant on this therapy than others.

For the majority of health insurance plans, orally administered (as opposed to intravenously injected) drugs are typically covered under the plan’s pharmacy benefit, which often has patient cost sharing requirements (copays, deductibles, etc.). This is different from cost sharing requirements for the plan’s medical benefit, under which most IV and injected medications are covered. As of 2013, 21 states have enacted oral chemotherapy parity legislation to help equalize patient out-of-pocket costs for oral chemotherapies and IV chemotherapies. Many of these laws generally require state-regulated health insurance companies and group health plans to cover orally administered anticancer drugs “on a basis no less favorable than” IV administered ones. According to the Kaiser Foundation¹⁴⁷, oral chemotherapy offers advantages important to overall quality of

life for patients and their family caregivers, including the convenience of not having to travel to a doctor's office or cancer treatment center as often as several times a week for IV infusions that can take several hours each time. This flexibility is particularly important for people living in rural areas, who otherwise would have to travel long distances to the nearest treatment facility, as well as for employed patients and family members who are trying to reduce hours away from work during treatment. When taken as directed and with appropriate counseling about their use, some of these medicines also offer the benefit of reduced and more manageable side effects.

Oral Chemotherapy Access Legislative Landscape – January 2013

● Active ● Passed/Signed



Cancer Survivorship

Approximately 13.7 million cancer survivors were estimated to be living in the US as of Jan. 2012¹⁴⁸. Improvements in the overall population health since the start of the 20th century have increased the life span from an average of 47.3 years in 1900¹⁴⁹ to 78.7 years in 2010¹⁵⁰, and one of the most common risk factors for cancer is growing older.¹⁵¹ Combined with advances in prevention, detection and treatment of cancer, the extended life span has led to growing numbers of people surviving cancer. Cancer has transitioned from the realm of a terminal disease to a chronic illness.

In this section, the environmental scan will address cancer survivorship. Health and public policy related to pre-existing conditions, prevention, chronic disease, and disability affect cancer survivors. A survivor as defined by the National Cancer Institute is “one who remains alive and continues to function during and after overcoming a serious hardship or life-threatening disease. In cancer, a person is considered to be a survivor from the time of diagnosis until the end of life.”¹⁵² Hence there are many forms of health and health related policy that may affect a cancer survivor. After surviving cancer, an individual has cancer as a pre-existing condition, which may affect their health and life insurance status. There is also the possibility of a reoccurrence of the old cancer, or the discovery of a new cancer, consequently cancer survivors also need to take preventative cancer measures. Though in remission, a cancer survivor requires ongoing monitoring, similar an individual with another chronic disease like hypertension who watches for the potential return or worsening of the condition. Depending on the site/location and severity of the cancer, a survivor may retain a physical and/or emotional disability as a result of having cancer.

The CDC ‘s *National Action Plan for Cancer Survivorship: Advancing Public Health Strategies Section IV Programs, Policies, and Infrastructure* has been used as an outline for this section of the report.

Table 10. Strategies on Cancer Survivorship		
Policy or Environmental Strategy	Source	What’s happening in Alaska?
<i>Develop, test, maintain, and promote patient navigation or case management programs that facilitate optimum care¹⁵³</i>		
Enhance survivor navigation services offered statewide	Alaska Cancer Survivorship Resource Plan 2013	Plan published, identifying priorities, resources and funding needed

Table 10. Strategies on Cancer Survivorship

Policy or Environmental Strategy	Source	What's happening in Alaska?
<p>Incentive care coordination – Affordable Care Act tests new and innovative models for reimbursement including:</p> <ul style="list-style-type: none"> • use comprehensive care plans; • promote care coordination between providers; • support care coordination for chronically ill patients at high risk of hospitalization; • use medication therapy management; • establish community-based health teams; • promote patient decision-support tools; • fund home health providers who offer chronic care management; • promote greater efficiency in inpatient and outpatient services; and • use a diverse network of providers to improve care coordination for individuals with two or more chronic illnesses and a history of prior hospitalization. 	Institute of Medicine	<p>Department of Health and Human Services proposed new rules on March 31, 2011 to create Accountable Care Organizations (ACOs) that incentivize health care providers to work together to treat patients. The rules will be finalized after public comment and subsequent revision.¹⁵⁴</p> <p>ACA established an optional Medicaid state plan benefit to establish “Health Homes” to coordinate care for people with Medicaid who have chronic conditions. As of Aug. 1, 2012, Alaska did not have an approved Health Home State Plan Amendment.^{155,156}</p>
Create financial incentives for doctors and hospitals to focus on quality, cost, or efficiency of care delivery	Institute of Medicine	<p>Department of Health and Human Services has proposed a rule that would link the amount of shared savings an ACO could receive to performance on quality of patient care.Error! Bookmark not defined. As part of ACA, organizations, hospitals, agencies, and providers have been incentivized based on performance.¹⁵⁷</p>
Encourage the use of effective health care delivery using frameworks such as the Chronic Care Model (CCM). Addresses multiple issues for managing chronic disease from self-management to delivery system designs, decision support, information technology, community linkages, and health care organizations.	Institute of Medicine	No known state or federal policies.

Table 10. Strategies on Cancer Survivorship		
Policy or Environmental Strategy	Source	What's happening in Alaska?
ACA created the Medicare Shared Savings Program to incentivize groups of providers and suppliers to work together through accountable care organizations (ACOs).	Institute of Medicine	Department of Health and Human Services proposed new rules on March 31, 2011 to create Accountable Care Organizations (ACOs) that incentivize health care providers to work together to treat patients. The rules will be finalized after public comment and subsequent revision. ¹⁵⁸
Encourage provider reimbursement models designed to better support and coordinate care	Institute of Medicine	The ACA specifies (Sec. 2717) that within two years of enactment, provider reimbursement structures will be revised to support improved health outcomes, prevent readmissions, and improve wellness and health promotion activities. ¹⁵⁹
<i>Develop and disseminate public education programs that empower survivors to make informed decisions</i>		
Develop and expand culturally and geographically appropriate programs for cancer survivors	Alaska Cancer Survivorship Resource Plan 2013	Plan published, identifying priorities, resources and funding needed

Table 10. Strategies on Cancer Survivorship		
Policy or Environmental Strategy	Source	What's happening in Alaska?
<i>Identify and implement programs proven to be effective (i.e. best practices)</i>		
ACA will require most individuals in the US to obtain health insurance	Institute of Medicine	Most individuals must have a qualified health insurance plan or pay a penalty tax beginning Jan. 1, 2014. ¹⁶⁰
ACA has given states the option to expand Medicaid to individuals below 133 percent of the federal poverty level beginning in Jan. 2014	Institute of Medicine	Governor Sean Parnell opposed expanding Medicaid in Alaska as of March 1, 2013, but may revisit the issue in Dec. 2013 ¹⁶¹
ACA will require health plans to offer essential health benefits package that includes chronic disease management	Institute of Medicine	Beginning in 2014, insurers will no longer be able to impose annual dollar limits on essential health benefits, including chronic disease management. ¹⁶²
<i>Implement evidence-based cancer plans that include all stages of cancer survivorship</i>		

Table 10. Strategies on Cancer Survivorship

Policy or Environmental Strategy	Source	What's happening in Alaska?
ACA offers the states an opportunity to offer Medicaid enrollees home and community based services and supports before individuals need institutional care.	Institute of Medicine	<p>Alaska Senior and Disabilities Services has revived recommendations for implementing the "Community First Choice" program and establishing a 1915(i) to offer State Plan Home and Community-Based Services but, as of Nov. 2012, tabled any consideration until further notice.¹⁶³</p> <p>Alaska does not qualify for the "Balancing Incentives" program due to historical spending on community and home-based settings above 50% of total Medicaid long-term medical assistance funds.¹⁶⁴</p> <p>The ACA created demonstration programs, including the Community-Based Transitions Program (CCTP) to test models to improve care transitions,¹⁶⁵ and the Independence at Home Demonstration to test the effectiveness of delivering primary care at home.¹⁶⁶ As of June, 2013, no organization in Alaska was involved in any of these programs.</p>
<i>Establish clinical practice guidelines for each stage of cancer survivorship</i>		
Promote evidence-based clinical practice guidelines related to cancer survivor care among primary care providers	Alaska Cancer Survivorship Resource Plan 2013	Plan published identifying priorities, resources and funding needed
As a part of ACA Medicare will offer full coverage for an "annual wellness visit" that includes a risk assessment and customized prevention plan.	Institute of Medicine	This benefit went into effect in 2011. ¹⁶⁷
Encourage the use of survivor care plans	Alaska Cancer Survivorship Resource Plan 2013	Plan published identifying priorities, resources and funding needed

Table 10. Strategies on Cancer Survivorship		
Policy or Environmental Strategy	Source	What's happening in Alaska?
<i>Promote policy changes that support addressing cancer as a long-term, chronic disease</i>		
The American with Disabilities Act (ADA) of 1990 and the ADA amendments Act of 2008 mandate reasonable accommodations for workers with disabilities. The four mandated areas are: employment protection; public service including transportation and accessibility; nondiscrimination in public accommodations and services offered by private entities; and telecommunication services. ¹⁶⁸ These accommodations could extend to individuals impacted by a cancer-related disability.	Institute of Medicine	The State of Alaska Americans with Disabilities Act (ADA) compliance program “coordinates statewide implementation of disability rights laws...” ¹⁶⁹
1996—The Health Insurance Portability and Accountability Act provided the first federal protections against genetic discrimination in health insurance. The act prohibited health insurers from excluding individuals from group coverage because of past or current medical problems, including genetic predisposition to certain diseases.	Institute of Medicine	The Alaska Department of Health and Social Services implements the HIPAA standards through the Alaska Medical Assistance Program. ¹⁷⁰
2008—The Genetic Information Nondiscrimination Act was designed to prohibit the improper use of genetic information in health insurance and employment. The act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals’ genetic information when making hiring, firing, job placement, or promotion decisions.	Institute of Medicine	Both parts I and II of the Genetic Information Nondiscrimination Act went into effect in 2009. ¹⁷¹

Table 10. Strategies on Cancer Survivorship		
Policy or Environmental Strategy	Source	What's happening in Alaska?
1965—Medicare and Medicaid, established through passage of the Social Security Amendments of 1965, provides federally subsidized health care to disabled and elderly Americans covered by the Social Security program. These amendments changed the definition of disability under the Social Security Disability Insurance program from “of long continued and indefinite duration” to “expect to last for not less than 12 months.”	Institute of Medicine	Medicaid is funded 50% by federal funds and 50% by the State of Alaska general funds, and administered by the Alaska Department of Health and Social Services Division of Public Assistance. ¹⁷² Medicare is administered federally, while the Alaska Medicare Information Office provides education and outreach to beneficiaries and their family members ¹⁷³
<i>Develop infrastructure to obtain quality data on all cancer management activities to support programmatic action</i>		
Develop an infrastructure for a comprehensive database on cancer survivorship	National Cancer Survivorship Plan	Alaska Cancer Registry funded by CDC ¹⁷⁴
Electronic Medical Records Use health information technology to improve patient-centered communication and care coordination in cancer care ¹⁷⁵	US Department of Health and Human Services, Office of Consumer eHealth	As part of the ACA, Electronic Health Record incentive programs opened on Jan. 3, 2011 ¹⁷⁶
Enabling cancer patients to access their data to help patients, families, and caregivers interpret data to support care coordination including shared decision-making and collaborative self-management. ¹⁷⁷	US Department of Health and Human Services, Office of Consumer eHealth	The Alaska Cancer Survivorship Resource Plan 2013 Priority 3 includes getting consent to release patient data at the beginning of a cancer diagnosis to support survivor navigation. ¹⁷⁸
Conduct ongoing evaluation of all activities to determine their impacts and outcomes and ensure continuous quality improvement of services	National Cancer Survivorship Plan	No known state or federal policies

Prevention of Cancer Reoccurrence

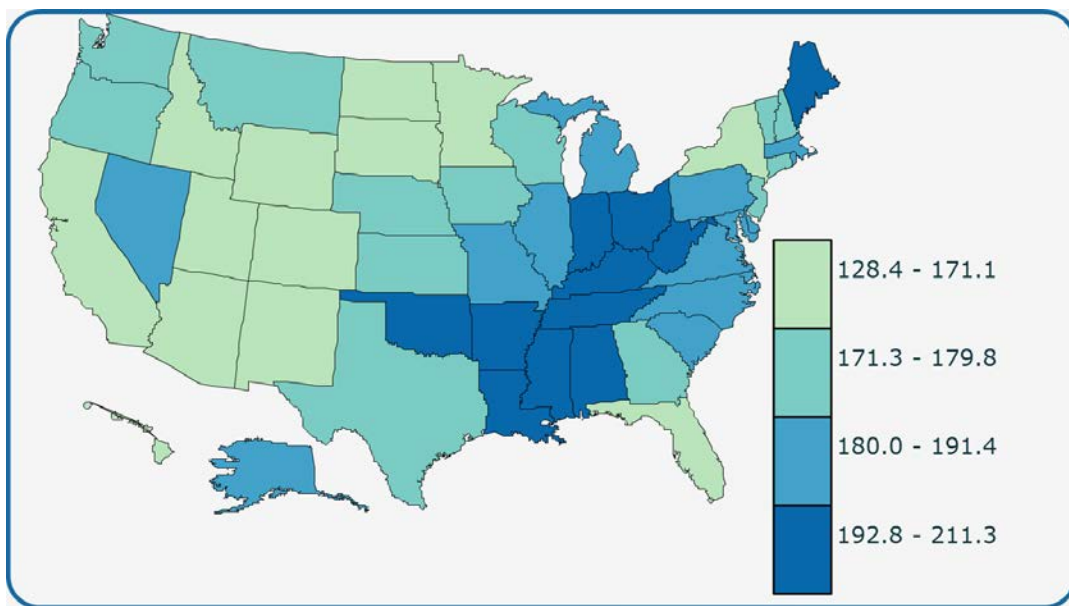
A priority for cancer survivors outlined in the National Cancer Survivorship Plan is the recurrence of cancer, and prevention of secondary cancers.¹⁷⁹ Policy and environmental strategies for prevention of cancer are outlined in the section on Cancer Prevention, and will not be detailed here.

Palliative and End of Life Care

While Alaska's cancer mortality rate is falling, 183 of every 100,000 population die from cancer in Alaska (see Figure 6).¹⁸⁰ Before addressing policies and environmental strategies related to palliative and end of life care, this section frames the issue with mortality data in a national context, Alaskan data reflects regional, racial, and gender disparities, as well as differences in impact by cancer site.

Mortality Data

Figure 6. Cancer Mortality Rates by State
Age-Adjusted Rates per 100,000, All Cancer Sites Combined, All Races, Male and Female, 2005-2009¹⁸¹



When compared to other states, Alaska has the 29th lowest rate of cancer mortality out of 51 (states + District of Columbia), with a rate of 183 per 100,000.¹⁸² The states with the lowest cancer death rates were Utah (128.4), Hawaii (147.8), Arizona (152.8) and Colorado (154.6), while the states with the highest rates of cancer death were Kentucky (211.3), West Virginia (206.6), Mississippi (204.7), and Louisiana (204.0) (See Figure 6).¹⁸³

While Alaska's cancer mortality rate has fallen by 1.2% on average between 2005-2009, the state ranks 33 out of 51 (50 states + the District of Columbia) for change in cancer death.¹⁸⁴ The states with the greatest average annual percentage change in cancer mortality rates between 2005-2009 among all cancers, all races, and all genders were Utah (-2.4%), Arizona (-2.3%), District of Columbia (-2.2%), and Louisiana (-2.2%).¹⁸⁴ The states that had the lowest average annual percentage change in cancer mortality rates between 2005-2009 were Minnesota (-0.2%), and Oklahoma, Nebraska, and Arkansas (-0.7%).¹⁸⁴ Cancer incidence rates per 100,000 vary dramatically throughout the state as shown in Figure 6, with the highest incidence rates in the North Slope Borough (616.2), Mat-Su

Borough (512.2), Wrangell-Petersburg Census Area (503.4), and Bristol Bay Borough (499.8).¹⁸⁶ The lowest cancer incidence rates per 100,000 were in the Aleutians East Borough (308.3), Aleutians West Census Area (314.7), Dillingham Census Area (343.8), and Wade Hampton Census Area (370.9).¹⁸⁵

Figure 7. Alaska Cancer Incidence Rates
Age-Adjusted Rates per 100,000, 2005-2009, All Cancer Sites, All Races, Both Sexes,
All Ages.¹⁸⁶

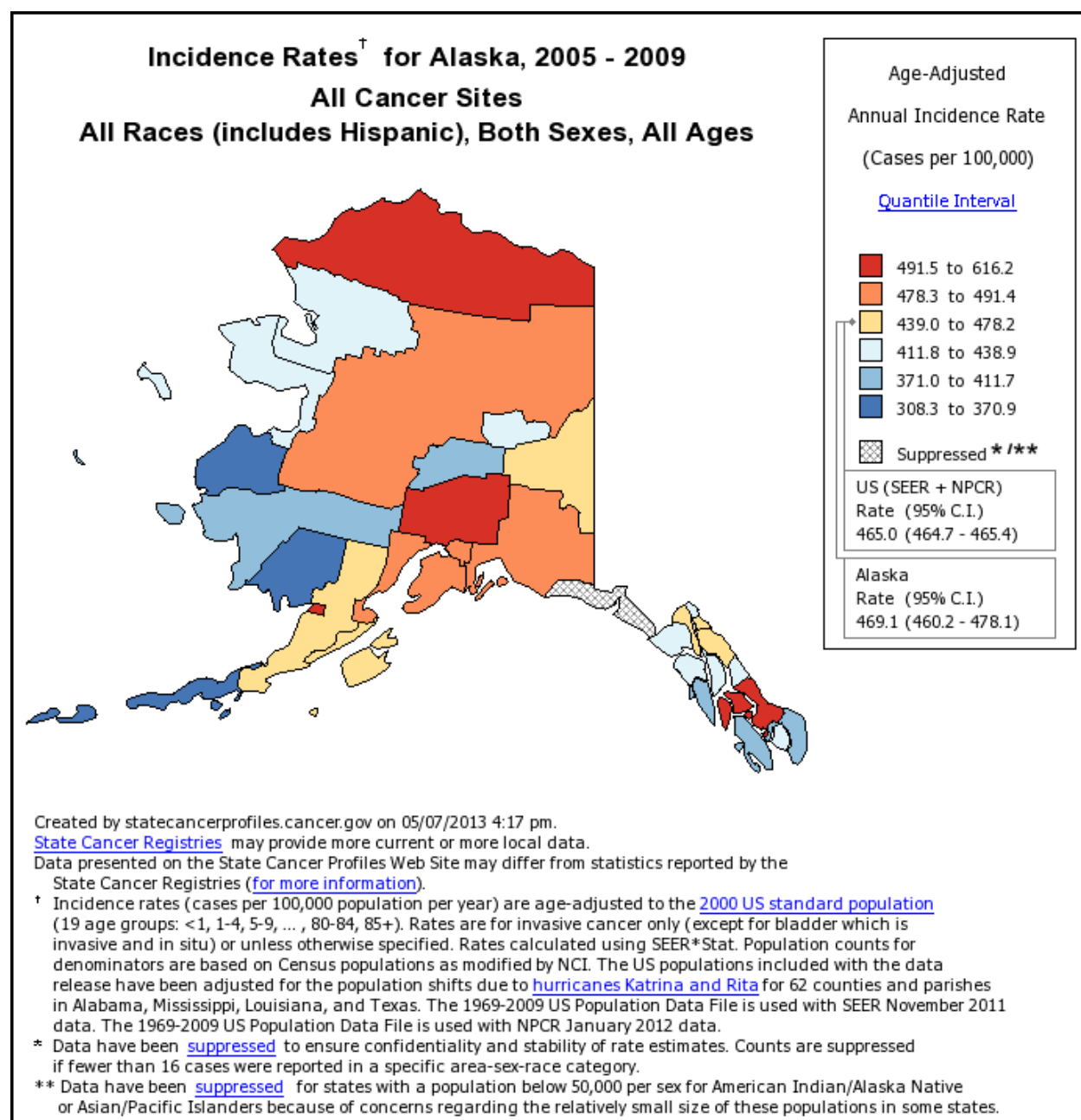
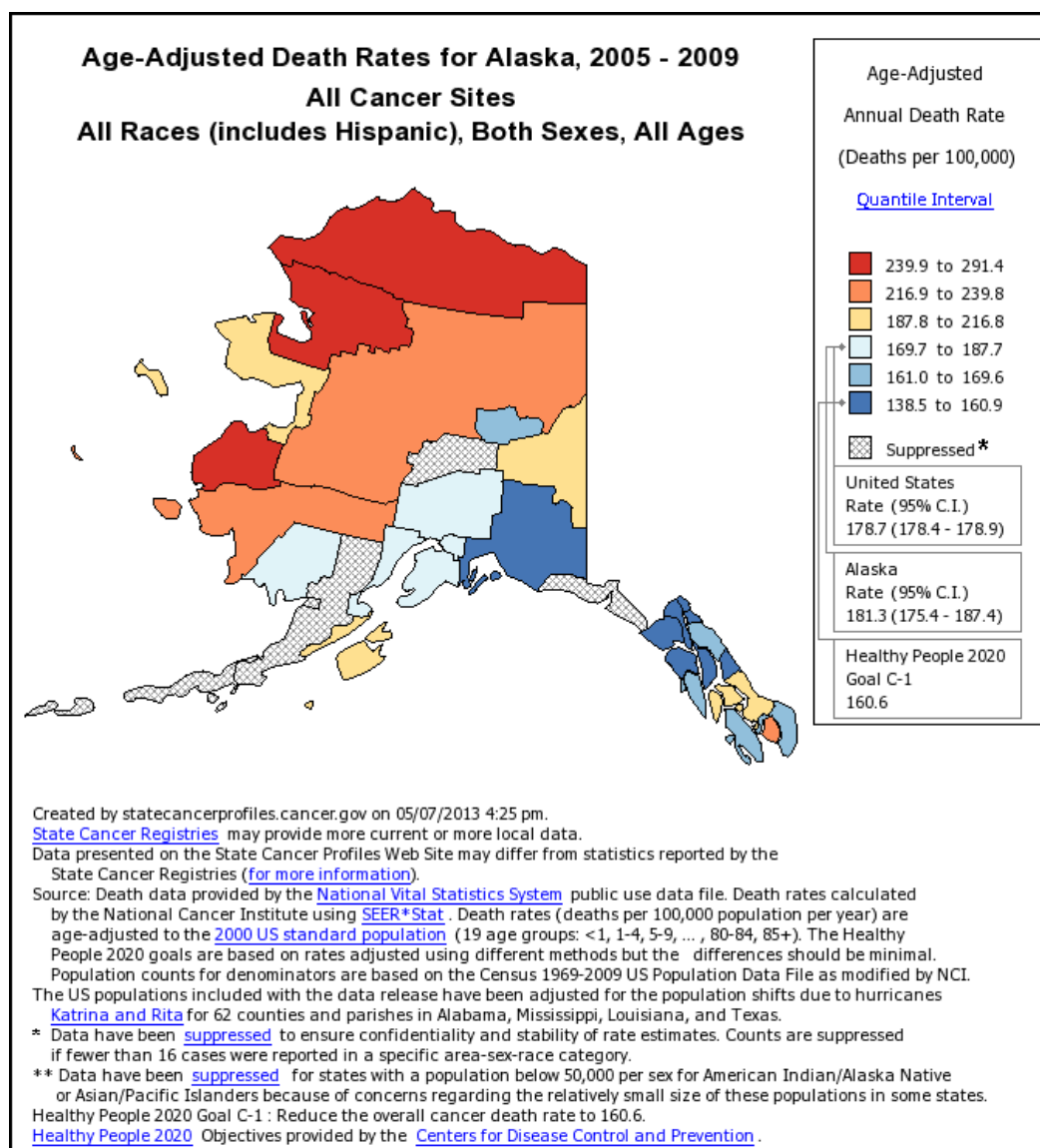
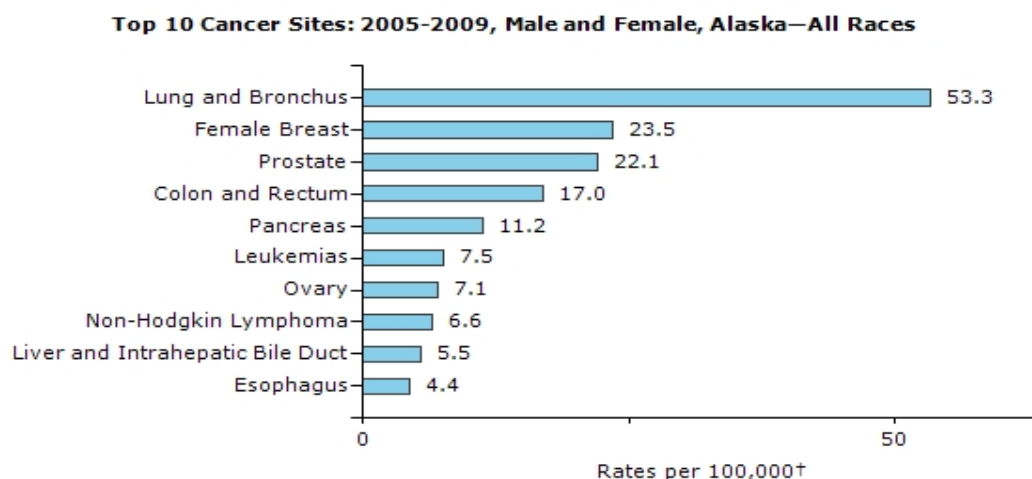


Figure 8. Alaska Cancer Mortality Rates
Age-Adjusted Rates per 100,000, 2005-2009, All Cancer Sites, All Races, Both Sexes,
All Ages¹⁸⁷



When contrasting the cancer incidence rate to the cancer death rate throughout the state (Figures 7 and 8), some noticeable differences emerge. Some regions have a large difference between the incidence rate and mortality rate (Mat-Su Borough, Valdez-Cordova Census Area, North Slope Borough, and Anchorage), implying that diagnosed individuals survive cancer at relatively high rates. However, some areas have a very low differences between the incidence rate and mortality rate (Wade Hampton Census Area, Dillingham Census Area, Northwest Arctic Borough, Bethel Census Area), implying that diagnosed individuals survive cancer at relatively low rates.¹⁸⁸

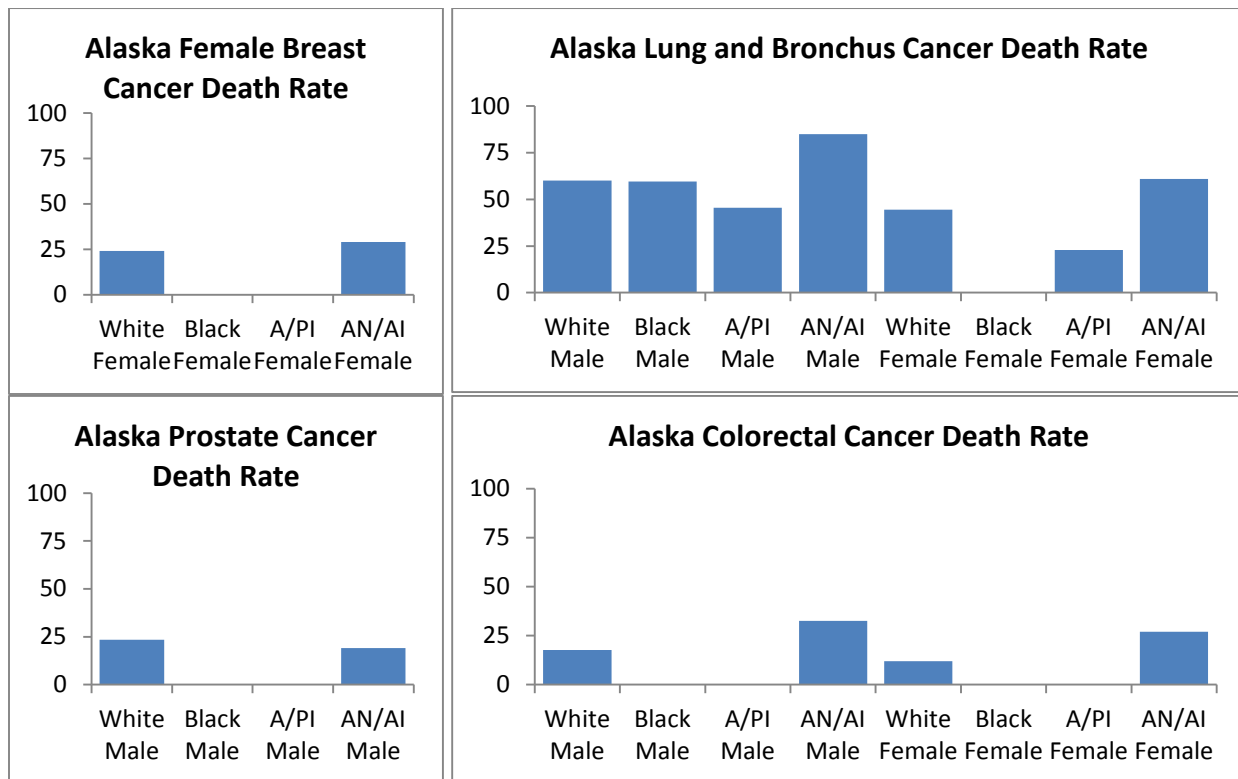
Figure 9. Age-Adjusted Cancer Mortality Rates for the Top 10 Cancers
Rates per 100,000 for the 10 Primary Sites with the Highest Rates in Alaska¹⁸⁹



Comparing the mortality rates of the top four cancers in Alaska shown in Figure 9 (lung and bronchus, female breast, prostate, and colon and rectum) with state rates nationwide, Alaska has one of the lowest rates of cancer death for prostate cancer (9 out of 51 with a rate of 22.1) and is in the top half for death rates of colon and rectum cancer (23 out of 51 with a rate of 20.0).**Error! Bookmark not defined.** However, Alaska ranks in the lower half for death rates due to cancer of the lung and bronchus (32 out of 51 with a rate of 53.3) and female breast cancer (32 out of 51 with a rate of 23.5).**Error! Bookmark not defined.**

From cancer mortality rates through 2009, breast, colon and rectum, lung and bronchus (male), prostate, and stomach cancer rates are falling in Alaska, while brain and ONS, lung and bronchus (female), ovary, and pancreas (female) cancer mortality rates have remained consistent. Leukemia (male), liver and bile duct (male), and pancreatic (male) cancer rates are rising.¹⁹⁰

Figure 10. Mortality Rates of the Top Four Cancers in Alaska
Rates per 100,000 by Race and Sex, 2005-2009.¹⁹¹



Lung cancer consistently caused the most cancer deaths between 2005-2009 in every examined race and sex category (see Figure 10).**Error! Bookmark not defined.** Data was only available for white and Alaska Native/American Indian (AN/AI) individuals for female breast cancer, prostate cancer, and colorectal cancer. While white Alaskan men had higher rates of death from prostate cancer when compared to AN/AI men, AN/AI individuals were inflicted with higher rates of cancer death from female breast cancer, lung and bronchus cancer, and colorectal cancer.

Palliative Care

End of life care for individuals whose cancer can no longer be controlled focuses on improving the quality of life of both patients and their loved ones.¹⁹² End-of-life care includes physical, mental, and emotional comfort, social support, as well as advance directives, pain management, and hospice care. End-of-life issues selected for this analysis of the cancer continuum are pain management, hospice, and advanced directives. The term “palliative care” is defined by the Commission on Cancer as referring to “patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering (National Quality Forum [NQF]). The availability of palliative care services is an essential component of cancer care, beginning at the time of diagnosis and being “continuously available” throughout treatment, surveillance, and, when applicable, during bereavement.”¹⁹³

Table 11. Strategies on Palliative Care		
Policy or Environmental Strategy	Source	What's happening in Alaska?
Accreditation by the Commission on Cancer (CoC). The CoC Standard is that palliative care services are available to patients either on-site or by referral. See Appendix I for a more complete description of the Commission on Cancer.	Commission on Cancer – American College of Surgeons 2012 ¹⁹⁴	Providence, Fairbanks Memorial and Alaska Regional Hospital participate in the Commission on Cancer accreditation program.

Pain Management

Efforts to address the pain of patients are often interrelated with the issue of drug abuse and addiction. Pain experienced by cancer patients is associated with the length of illnesses, site, and severity. Cancer patients with significant pain may need controlled substances that contain opiates. Due to misunderstanding of pain management, cancer patients can be mislabeled as ‘addicts’ or drug seeking patients. This may lead to patients receiving insufficient, or nonexistent, care for pain. Practitioners who work with pain management may also have their legitimacy and their practice questioned. Officially adopted policies, such as laws (statutes) and regulations can promote or interfere with pain management. While no specific pain management strategies have been acknowledged at the national level, the University of Wisconsin Pain and Policy Studies Group has a research program aimed at improving US drug control and health care policies related to pain management, palliative and end-of-life care. Several extracts (direct quotes) from their report *Achieving Balance in Federal and State Pain Policy A guide to Evaluation (CY 2012)* on state and federal statutes are included in Appendix IV¹⁹⁵. Research criteria was established as part of this evaluation to identify and assess existing statutes, regulations relative to their enhancement or impediment to safe and effective pain management.

At the federal level there are several organizations with statutes that affect pain management. Statutes in the Food and Drug Administration support pain management by clarifying that the regulation of controlled substances should not impede legitimate medical use; they establish that controlled substances are necessary for public health and determine that the Food and Drug administration has the responsibility to measure the effect through the process of a Risk Evaluation and Mitigation Strategy on safe drug use and patient care.

Most federal public health and welfare statutes enhance safe and effective pain management. They establish:

- a way to determine if programs that monitor prescriptions impede the appropriate use of control substances;
- support of medical provider training to include pain management as an important part of patient care, and evaluate the impact of the training;

- support for pain management as a broad initiative throughout NIH and the Department of Health and Human Services and other Federal agencies.

Federal statutes also distinguish between physician assisted suicide and prescribing a controlled substance for pain management.

Within the Code of Federal Regulation for food and drugs, public health, and welfare it is recognized that prescriptions for control substances are a legitimate part of practicing medicine and that addiction is different than the development of a physical dependence on a pain relief when used for pain management.

Alaska statutes that support pain management can be found in both the Controlled Substances Act and Pharmacy Practice Act. Both clarify the control substance – opioids- can be prescribed and administered as a part of the practice of medicine.

Hospice

Hospice, as defined by the National Cancer Institute:

“is a special type of care in which medical, psychological, and spiritual support are provided to patients and their loved ones when cancer therapies are no longer controlling the disease. Hospice care focuses on controlling pain and other symptoms of illness so patients can remain as comfortable as possible near the end of life. Hospice focuses on caring, not curing. The goal is to neither hasten nor postpone death. If the patient’s condition improves or the cancer goes into remission, hospice care can be discontinued and active treatment may resume. Choosing hospice care doesn’t mean giving up. It just means that the goal of treatment has changed.”¹⁹⁶

Hospice is a part of palliative care. It refers to a specific model for delivering palliative care at the end-of-life. Hospice services are usually limited to the last six months of life.¹⁹⁷ Social security statutes related to Medicare and Medicaid as detailed by the National Hospice and Palliative Care Organization are listed in the table for Hospice.

There are a number of federal organizations with regulations that guide hospices. The list of organizations is in Appendix V.

Table 12. Hospice Strategies

Policy or Environmental Strategy	Source	What's happening in Alaska?
Pain Management	Pain and Policy Studies Group ¹⁹⁸	<p>Alaska regulations establish that hospices ensure pain management as a part of patient care by establishing that a practitioner can administer drugs. The statute is included within a section on hospice agencies:</p> <p>“HOSPICE AGENCIES Title 7. Health and Social Services; Part 1. Administration; Chapter 12. Facilities and Local Units; Article 7. Hospice Agencies”</p> <p>The text of the statute defines who can administer drugs:</p> <p>“Alaska Stat. § 08.80.480 Sec. 08.80.480. Definitions In this chapter, unless the context otherwise requires... (28) "practitioner" means an individual currently licensed, registered, or otherwise authorized by the jurisdiction in which the individual practices to prescribe and administer drugs in the course of professional practice...”</p>
“1989 Medicare updated the rules for the hospice benefit. The Omnibus Budget Reconciliation Act allowed reimbursement for hospice services for nursing home residents receiving Medicare and Medicaid.” ¹⁹⁹	Oncology Nursing Society ²⁰⁰	<p>No known state policy</p> <p>Medicare allows for the reimbursement of hospice in Alaska.</p>

Table 12. Hospice Strategies

Policy or Environmental Strategy	Source	What's happening in Alaska?
<p>“Medicare, Medicaid, and State Children’s Health Improvement Program Benefits Improvement Act of 2000 (Consolidation Appropriations Act, 2001²⁰¹) clarified the certification for a terminal illness as based on physicians clinical judgment regarding the normal course of the disease. This was important to improving access to hospice care as Medicare requires physicians to certify that patients have six months or less to live which affected the willingness of hospices to accept patients whose conditions might improve.”²⁰²</p> <p>“In addition, the Consolidation Appropriations Act of 2001:</p> <ul style="list-style-type: none"> • Restored Medicare cuts implemented in 1997 Balanced Budget Act • Provided for 5% increase in Medicare daily payment rates for hospice • Required Medicare Payment Advisory Commission to study factors affecting hospice utilization • Required demonstration project with disease management services for advanced chronic illness.”²⁰³ 	<p>Oncology Nursing Society²⁰⁴</p>	<p>No known state policy</p> <p>Medicare, as a national program that follows beneficiaries, is applicable in Alaska.</p>
<p>The Assisted Suicide Funding Restriction Act of 1997 authorized federal initiatives that include research, training, and demonstration projects to improve access to hospice.^{205, 206}</p>	<p>Oncology Nursing Society²⁰⁷</p>	<p>No known state policy</p> <p>The federal initiative is applicable in Alaska.</p>

Table 12. Hospice Strategies

Policy or Environmental Strategy	Source	What's happening in Alaska?
<p>Congress added a hospice benefit to the Medicare statutes under the Social Security Act in 1982. The following is a list of relevant statutes.</p> <p>“Medicare Hospice Statutes</p> <ul style="list-style-type: none"> • SSA 1812(a) – Scope of hospice benefits and educational consultation for beneficiaries who are terminally but have not elected the hospice benefit • SSA 1812(d) – Scope of hospice benefits and waiver of other services, revocation and transfer • SSA 1813(a)(4) – Deductibles and coinsurance applicable to hospice care • SSA 1814(a)(7) – Certification of terminal illness, plan of care, face-to-face encounter • SSA 1814(i) – Payment for hospice care, including payment reform, hospice cap, aggregate cap, data collection and cost reporting requirements • SSA 1861(dd) – Definitions, hospice care, hospice program, attending physician, terminally ill, interdisciplinary group, use of volunteers, traveling patients, multiple locations, and specialized nursing • SSA 1862- Exclusions from coverage; in the case of hospice care, excludes from coverage items and services not reasonable and necessary for the palliation or management of terminal illness. <p>Medicaid Hospice Statutes</p> <ul style="list-style-type: none"> • SSA 1902(a)(10) – For individuals electing to receive hospice care, such assistance may not be made available in an amount, duration or scope less than that provided under Medicare. • SSA 1902(a)(13)(B) – Medicaid payment for hospice care must be no less than Medicare mounts, and must use the same methodology, and must pay for nursing home room and board for certain dual eligible patients, at a rate that is 95% of what the State otherwise would have paid for that individual in that facility. • (SSA 1905(a) – The term “medical assistance” includes hospice care • SSA 1905(o) – Optional hospice benefits; definition of hospice care; coverage of nursing home and ICF/MR room and 	<p>National Hospice and Palliative Care Organization</p>	<p>Medicare, as a national program that follows beneficiaries, is applicable in Alaska.</p>

Advance Directives

In the event that a person is unable to make decisions about their medical care, advance directives should communicate their decisions to family, friends, and health care professionals. People should be healthy when they fill out their advance directives so they have time to think about the end-for-life care they would desire if they were unable to communicate their wishes. Completing the directives while being healthy allows a person time to share and discuss their decision with loved ones. Laws vary from state to state regarding advance directives hence it is important for the person to complete the directive in the state where they expect to receive care.²⁰⁹

Table 13. Strategies on Advance Directives

Policy or Environmental Strategy	Source	What's happening in Alaska?
SSA 1902(w) – Advance directives; information must be provided to hospice patients at the time of initial receipt of care. ²¹⁰ Federal Patient Self-Determination Act 1991 requires hospitals to distribute living will forms to patients at admission. Directive is intended to make clear a patient's desire about the extent of life-saving treatments and to lessen the burden on families when decisions need to be made.	Oncology Nursing Society ²¹¹	The state of Alaska has a statute that addresses advance directives: Alaska Statutes 13.52.010 - Advance health care directives. The statute text is included in Appendix VI.

Nurses and nursing care are important in palliative and end of life care. Nurses play a significant role in hospice/palliative care. They are often one of the primary care givers for terminally ill patients. In addition to clinical nursing duties of observing and recording symptoms and providing treatments, they also provide psychological, psychosocial and spiritual support to terminally ill patients and their families. Nursing initiatives and legislation that address nurse shortages and training can improve palliative and end of life care. This portion of the analysis focuses on nursing policy initiatives and legislation, and their implications on end-of-life care for cancer patients.

Table 14. Strategies on Provider/Practitioner Education and Training, and Palliative Care		
Policy or Environmental Strategy	Source	What's happening in Alaska?
The End-of-Life Nursing Education Consortium (ELNEC) ²¹² project is a national education initiative to improve palliative care. The project provides undergraduate and graduate nursing faculty, CE providers, and staff development educators, specialty nurses in pediatrics, oncology, critical care and geriatrics, and other nurses with training in palliative care so they can teach this essential information to nursing students and practicing nurses. The project began in February 2000. ²¹³	Oncology Nursing Society ²¹⁴	Alaska has ELNEC and ELNEC for Veterans trainers located in Anchorage, Alaska ²¹⁵

Table 15. Strategies on Nursing and Palliative Care

Policy or Environmental Strategy	Source	What's happening in Alaska?
<p>"The Nurse Reinvestment Act (P.L. 107-205) addresses the nursing shortage and was passed by Congress in 2002. The act authorizes grants for various recruitment and retention strategies to promote the nursing profession.</p> <ul style="list-style-type: none"> • Public service announcements to promote the nursing profession and encourage people to enter the nursing profession • National Nurse Service Corps Scholarship Program for nursing students in exchange for working in facilities with a shortage of nurses after graduation • New technologies in education such as distance learning • Career ladder programs to promote advancement in the nursing profession • Internships and residency programs to encourage mentoring and specialty training • Program to promote nursing involvement in organizational decision making • Geriatric care training programs for nursing faculty and students • Faculty loan program to provide loan repayments in exchange for teaching commitments."²¹⁶ 	<p>Oncology Nursing Society²¹⁷</p>	<p>The federal nursing education loan repayment program is available in Alaska. It is under USDHHS, HRSA, Bureau of Health Professions, Division of Nursing.²¹⁸</p>

While no known state policy exists in Alaska, additional federal legislation that relates to palliative care, as documented by the Oncology Nursing Society²¹⁹ includes:

Healthcare Research and Quality Act of 1999, in summary:

- Designated people who need chronic or end-of-life care as priority population
- Directed the Agency for Healthcare Research and Quality to support research, demonstration projects, and evaluations with respect to the delivery of healthcare services in inner city and rural areas and healthcare for underserved²²⁰

Older Americans Act Amendments of 2000, in summary:

- Created National Family Caregiver Support Program

- Established grants for caregiver support programs and provided funding to states to offer support services for family caregivers
- Awarded grants for caregiving projects to state agencies on aging, community service providers, Native American support programs, universities, and national aging organizations²²¹

Limitations

All nationally acknowledged policy and environmental strategies, as well as those acknowledged by professional organizations, are time specific. As innovative practices are evaluated and research is published and revised, new practices will become recognized as effective while current strategies may be revised to improve their effectiveness. This report was written in June 2013, and is consequently limited to the policy and environmental strategies acknowledged or recommended at this time. Our scope of research was limited to national governmental and professional organizations for the prevention and diagnosis sections, and branched into policies acknowledged by professional organizations for the treatment and end of life sections. Consequently, policies and strategies not recommended or acknowledged by these organizations have not been included. In addition, our search for Alaskan practice was limited to those in concordance with our findings, and enacted at the state level.

Conclusions

While the federal government and Alaska have enacted numerous policy and environmental strategies to improve outcomes along the cancer continuum, there remain areas for improvement. This report inventories state and national policy and environmental strategies recognized at a national level, however, additional analysis would be required of each strategy to determine its effectiveness within an Alaskan context. The sections of this document on incidence and mortality data also briefly illustrate regional, racial, and gender disparities related to cancer, as well as the divergent impacts of different cancers. Each of these variations, in addition to other contextual factors within Alaska, would also need to be considered when addressing the impact of particular policies at a local, regional, or state-wide level. This report is written for the Chronic Disease Prevention and Health Promotion Section of the Alaska Department of Health and Social Services Division of Public Health. We anticipate that the recipients of this report will construct a cancer policy agenda in Alaska by determining the feasibility, potential effectiveness, and prioritization of these policy and environmental strategies in an Alaskan context, in consideration of the variation between regions, genders, races, cancer sites, etc.

Appendix I. Commission on Cancer Accreditation

According to the latest Cancer program Standards report²²², the multidisciplinary Commission on Cancer:

- " Establishes standards to ensure quality, multidisciplinary and comprehensive cancer care delivery in health care settings.
- Conducts surveys to assess compliance with those standards.
- Collects standardized high-quality data from CoC-accredited health care settings.
- Uses data to measure cancer care quality and to *monitor treatment patterns and outcomes*.
- Supports and enhances cancer control.
- Monitors clinical surveillance activities.
- Develops effective educational interventions to improve cancer prevention, early detection, care delivery, and outcomes in health care settings."

The Cancer Program Standards 2012 cites five key elements to the success of a CoC-accredited cancer program²²³:

1. "The clinical services provide state-of-the-art pretreatment evaluation, staging, treatment, and clinical follow-up for patients with cancer seen at the program for primary, secondary, tertiary, or end-of-life care.
2. The cancer committee leads the program through setting goals, monitoring program activity, and evaluating patient outcomes and improving care.
3. The cancer conferences provide a forum for patient consultation and contribute to physician education.
4. The quality improvement (QI) program is the mechanism for evaluating and improving patient outcomes.
5. The cancer registry and database are the basis for monitoring the quality of care."

These keys to success are classified in five broad categories²²⁴ that have a set of standards accredited facilities are expected to meet. The five categories are:

- Program Management
- Clinical Services
- Continuum of Care Services
- Patient Outcomes
- Data Quality

Below are the standards that are most closely related to treatment¹² by category.

Physician Credentials (Program Management)²²⁵

¹² The designation is subjective given that many standards fall in more than one category. For a full list: <http://www.facs.org/cancer/coc/programstandards2012.pdf>

Treatment is administered by practitioner(s) who are either board certified or in the process of becoming certified. Specifically, diagnostic and treatment services are provided by, or referred to, the leadership and cancer program evaluation and management team physicians who are currently board certified, or the equivalent, in their general specialty, or are in the process of becoming board certified.

Nursing Care (Clinical Services)

Oncology nursing care is provided by nurses with specialized knowledge and skills. Competency is evaluated annually.

Monitoring Compliance with Evidence-Based Guidelines (Patient Outcomes):

Each year, a physician member of the cancer committee performs a study to assess whether patients within the program are evaluated and treated according to evidence-based national treatment guidelines. Study results are presented to the cancer committee and documented in cancer committee minutes.

Follow-Up of all Patients (Data Quality):

For all eligible analytic cases, an 80% follow-up rate is maintained from the cancer registry reference date.

Follow-Up of recent Patients (Data Quality)

A 90% follow-up rate is maintained for all eligible analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whichever is shorter.

Appendix II. Revenue Generation for Increasing Awareness, Prevention and Treatment

States can raise “pink dollars” for breast cancer research and prevention programs. For the purposes of the study cited below, pink dollars refers to revenue generated for breast cancer advocacy or research efforts. States can generate pink dollars by collecting donations on state income tax forms, fees from specialty license plates, and revenue from specialty state lottery tickets. Proceeds from these initiatives are slated for breast cancer research foundations or state early detection and prevention programs.

An income tax check-off program is a method in which a taxpayer checks off a contribution to state programs on a state personal income tax form. The use of these tax return check-off boxes to fund charitable organizations began in 1972 for federal forms and in 1977 for state forms with the implementation of the Colorado wildlife check-off program. An audit in 2000 indicated that total taxpayer donations to check-off programs had reached \$32.8 million.

Information on U.S income tax check offs for breast cancer prevention and early detection by state and year (up to 2009) ²²⁶

State	Year of initiation	Beneficiary organization	Average annual donation
Alabama	2001	Alabama Breast and Cervical Cancer Research program through the University of Alabama at Birmingham	NA
California	1994	California Breast Cancer Research Program	\$935,500
Colorado	2007	Colorado Breast and Women's Reproductive Cancers Check-Off Fund	\$115,000
Connecticut	1997	Connecticut Department of Public Health	\$93,800
Delaware	1996	Delaware Chapter of the National Breast Cancer Coalition	\$10,000
Georgia	2000	Georgia Cancer Research Fund	\$200,000
Illinois	1993	Penny Severns Breast and Cervical Cancer Research Fund	\$325,000
Kansas	2005	University of Kansas Cancer Center	\$85,700
Kentucky	2005	Kentucky Breast Cancer Research and Education Trust Fund	\$50,000
Michigan	2007	Amanda's Fund for Breast Cancer Prevention and Treatment	\$71,600
Missouri	2008	Friends of the Missouri Women's Council	NA
New Jersey	1995	New Jersey Breast Cancer Research Fund	\$235,000
New York	1997	New York Breast Cancer Research and Education Fund	\$590,800
Oklahoma	1994	Breast Cancer Fund	\$15,000
Oregon	2005	Oregon Susan G. Komen Breast Cancer Foundation affiliate	\$13,100
Pennsylvania	1997	Breast and Cervical Cancer Initiative	\$190,000
Virginia	2009	Every Woman's Life Breast and Cervical Cancer Fund	NA
Wisconsin	2004	Medical College of Wisconsin	\$214,000

According to the study, Alaska is not one of the states that have such a program.

Specialty license plates allow motorists to advertise their support for a cause, school spirit, military service, or organizational membership. State residents can order the plate for an extra annual fee, a percentage of which goes to a specified cause or organization. States favor specialty plates because they typically boost transportation revenues by increasing the amount of money motorists pay for license plates. Currently, the number of plates offered per state ranges from one in New Hampshire to more than 800 in Maryland, with a mean of 50 across the states. Due to funding cuts, an increasing number of organizations are using specialty license plates as a means of generating revenue. Georgia for example in 2003 enacted a legislation that requires the issuance of special license plates to support

breast cancer programs for the medically indigent. Monies from the sale of these license plates must be used to fund cancer screening and treatment related programs for those persons who are medically indigent and may have breast cancer.

The table below summarizes the amounts raised by different states through 2009:

Information on U.S income tax check offs for breast cancer prevention and early detection by state and year (up to 2009) ²²⁷

State	Year of initiation	Additional cost	Beneficiary organization	Amount of proceeds	Amount raised ^a
Alabama	1998	\$50	Breast Cancer Research Foundation of Alabama	\$41.50	\$58,000
Alabama	2008	\$50	Joy to Life Foundation	\$41.50	April–October 2009: \$23,000
Arizona	2006	\$25	Arizona Department of Health Services	\$17.00	2008: \$150,000
Arkansas	2003	\$35	Arkansas Breast Cancer Research Fund	\$25.00	2008: \$112,935
Colorado	2005	\$75	Breast and Cervical Cancer Prevention and Treatment Fund ^c	\$25.00	NA ^b
Connecticut	2004	Suggested \$50 donation	Connecticut Breast Cancer Coalition Foundation	Donation	\$4,500
Florida	2001/2002	\$30	Florida Breast Cancer Foundation	\$25.00	2007: \$509,450
Georgia	2001/2002	\$45	Office on Women's Health	\$22.05	2009: \$846,256
Idaho	2006	\$35	Idaho Primary Care Association and Community Health Centers	\$25.00	2007–2009: \$26,000
Illinois	1999	\$25	Susan G. Komen Breast Cancer Foundation	\$23.00	NA ^b
Indiana	2005	\$40	Indiana Breast Cancer Awareness Trust	\$25.00	\$855,000
Iowa	2003	\$35	Iowa Breast Cancer Awareness Fund and Susan G. Komen Breast Cancer Foundation	\$35.00 initial	August 2009–April 2010: \$15,844
Kansas	2008	\$50 (tax deductible)	University of Kansas Cancer Center	\$50.00	2007: \$90,287 2008: \$60,403 2009: \$90,287
Kentucky	2005	\$44	Kentucky Breast Cancer Research and Education Trust Fund	\$10.00	\$300,000
Louisiana	2008	\$25	Susan G. Komen Breast Cancer Foundation Los Angeles affiliate	\$21.50	\$52,675
Maine	2008	\$20	Maine Breast Cancer Support Service Fund, Women's Cancer Research Fund of the Maine Cancer Foundation, Mammogram Fund of the Maine Breast and Cervical Health Program	NS	2008–2009: \$93,000
Maryland	2007	\$25	Susan G. Komen, MD	\$25.00	\$6,775
Massachusetts	2006	\$40	Diane Connolly-Zaniboni Breast Cancer Research Fund at Tufts Medical Center in Boston	NS	2006–2009: \$260,000
Mississippi	2004	\$31	North and Central Mississippi affiliates of the Susan G. Komen Breast Cancer Foundation	\$24.00 ^d	Average of \$2,500 every month
Missouri	2003	\$25 (tax deductible)	Friends of the Missouri Women's Council	\$25.00	2008: \$35,000
New Mexico	2008	\$37	New Mexico Department of Health—Breast and Cervical Cancer Early Detection Program	\$25.00	\$4,625
North Carolina	2004	\$20	\$10 Special Registration Plate Account, the \$10 Collegiate and Cultural Attraction Plate Account	\$0.00	NA ^b
Ohio	2005	\$35	Breast Cancer Fund of Ohio	\$25.00	\$80,000 up to 2008
Oklahoma	1996	\$38	Belle Maxine Hilliard Breast and Cervical Cancer Treatment Fund	NS	2005: \$24,648 2006: \$24,606 2007: \$23,958 2008: \$24,116 2009: \$24,597
Pennsylvania	2005	\$34	Pennsylvania Breast Cancer Coalition	\$14.00	2009: \$4,000
Tennessee	2009	\$35	Tennessee affiliates of the Susan G. Komen Breast Cancer Foundation	\$15.62	NA ^b
Virginia	2000	\$25	Virginia Breast Cancer Foundation	\$15.00	2007: \$105,500 2008: \$117,000 2009: \$125,000

^aAmounts reported as indicated from recipient organizations. Time frames vary.

^bFunds not calculated due to the funds not being collected for breast cancer purposes (Colorado and North Carolina) or the program being too new at the time of this study to have data on the amount of funds collected (Illinois and Tennessee)

^cIn addition to all other taxes and fees, a person renewing a breast cancer license plate on or before June 30, 2012, shall have the option to pay a \$25.00 Breast and Cervical Cancer Prevention and Treatment Fund surcharge, but shall not be required to pay the \$25.00 surcharge to renew. On or after July 1, 2012, a person renewing a breast cancer license plate shall pay a \$25.00 Breast and Cervical Cancer Prevention and Treatment Fund surcharge.

^d\$2.00 to State Highway Fund, \$2.00 to Tax Collection Commission, \$1.00 to each of Mississippi Burn Center, Department of Revenue, and Mississippi Department of Archives and History

NA = not applicable

Appendix III. Federal Mandates Related to Pain Management

These sections are quoted from the Pain and Policy Studies Group. *Achieving Balance in Federal and State Pain Policy: A Guide to Evaluation (CY 2012)*. University of Wisconsin Carbone Cancer Center. Madison, WI.

Federal Statutes:

CONTROLLED SUBSTANCE ACT

Title 21. Food and Drugs;

Chapter 13. Drug Abuse Prevention and Control

21 USCS § 355-1

§ 355-1. Risk evaluation and mitigation strategies

.

(f) Providing safe access for patients to drugs with known serious risks that would otherwise be unavailable.

.

(5) Evaluation of elements to assure safe use. The Secretary, through the Drug Safety and Risk Management Advisory Committee (or successor committee) of the Food and Drug Administration, shall--

(A) seek input from patients, physicians, pharmacists, and other health care providers about how elements to assure safe use under this subsection for 1 or more drugs may be standardized so as not to be--

(i) unduly burdensome on patient access to the drug; and

(ii) to the extent practicable, minimize the burden on the health care delivery system;

(B) at least annually, evaluate, for 1 or more drugs, the elements to assure safe use of such drugs to assess whether the elements--

(i) assure safe use of the drug;

(ii) are not unduly burdensome on patient access to the drug; and

(iii) to the extent practicable, minimize the burden on the health care delivery system; and

(C) considering such input and evaluations--

(i) issue or modify agency guidance about how to implement the requirements of this subsection; and

(ii) modify elements under this subsection for 1 or more drugs as appropriate.

..

21 USCS § 801

§ 801. Congressional findings and declarations: controlled substances

The Congress makes the following findings and declarations:

(1) Many of the drugs included within this title have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.

.

21 USCS § 801a

§ 801a. Congressional findings and declarations: psychotropic substances

The Congress makes the following findings and declarations:

.

(3) In implementing the Convention on Psychotropic Substances, the Congress intends that, consistent with the obligations of the United States under the Convention, control of psychotropic substances in the United States should be accomplished within the framework of the procedures and criteria for classification of substances provided in the Comprehensive Drug Abuse Prevention and Control Act of 1970. This will insure that (A) the availability of psychotropic substances to manufacturers, distributors, dispensers, and researchers for useful and legitimate medical and scientific purposes will not be unduly restricted; (B) nothing in the Convention will interfere with bona fide research activities; and (C) nothing in the Convention will interfere with ethical medical practice in this country as determined by the Secretary of Health, Education, and Welfare [Secretary of Health and Human Services] on the basis of a consensus of the views of the American medical and scientific community.

PUBLIC HEALTH AND WELFARE

Title 42. Public Health and Welfare

42 USCS § 201

§ 201. Definitions

.

(q) The term "drug dependent person" means a person who is using a controlled substance (as defined in section 102 of the Controlled Substances Act [21 USCS § 802]) and who is in a state of psychic or physical dependence, or both, arising from the use of that substance on a continuous basis. Drug dependence is characterized by behavioral and other responses which include a strong compulsion to take the substance on a continuous basis in order to experience its psychic effects or to avoid the discomfort caused by its absence.

42 USCS § 280g-3

§ 280g-3. Controlled substance monitoring program

.

(j) Studies and reports.

(1) Implementation report.

(A) In general. Not later than 180 days after the date of enactment of this section [enacted Aug. 11, 2005], the Secretary, based on a review of existing State controlled substance monitoring programs and other relevant information, shall determine whether the implementation of such programs has had a substantial negative impact on--

(i) patient access to treatment, including therapy for pain or controlled substance abuse;

...

(2) Progress report. Not later than 3 years after the date on which funds are first appropriated under this section, the Secretary shall--

(A) complete a study that--

(i) determines the progress of States in establishing and implementing controlled substance monitoring programs under this section;

(ii) provides an analysis of the extent to which the operation of controlled substance monitoring programs have reduced inappropriate use, abuse, or diversion of controlled substances or affected patient access to appropriate pain care in States operating such programs;

42 USCS § 284q

§ 284q. Pain research

(a) Research initiatives.

(1) In general. The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

(2) Annual recommendations. Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken with funds reserved under section 402A(c)(1) [42 USCS § 282a(c)(1)] for the Common Fund or otherwise available for such initiatives.

(3) Definition. In this subsection, the term "Pain Consortium" means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

(b) Interagency Pain Research Coordinating Committee.

(1) Establishment. The Secretary shall establish not later than 1 year after the date of the enactment of this section [enacted March 23, 2010] and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the "Committee"), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

....

42 USCS § 294i

§ 294i. Program for education and training in pain care

(a) In general. The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities for the development and implementation of programs to provide education and training to health care professionals in pain care.

(b) Certain topics. An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on--

(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

(2) applicable laws, regulations, rules, and policies on controlled substances, including the degree to which misconceptions and concerns regarding such laws, regulations, rules, and policies, or the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

(5) recent findings, developments, and improvements in the provision of pain care.

(c) Evaluation of programs. The Secretary shall (directly or through grants or contracts) provide for the evaluation of programs implemented under

subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

42 USCS § 14402

§ 14402. Restriction on use of Federal funds under health care programs

....

(b) Construction and treatment of certain services. Nothing in subsection (a), or in any other provision of this Act (or in any amendment made by this Act), shall be construed to apply to or to affect any limitation relating to--

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

CONTROLLED SUBSTANCES REGULATIONS

Title 21. Food and Drugs

21 CFR 1306.04

§ 1306.04 Purpose of issue of prescription.

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

PUBLIC HEALTH

Title 42. The Public Health

42 CFR 8.2

§ 8.2 Definitions.

The following definitions apply to this part:

.

Opiate addiction is defined as a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opiates despite significant opiate-induced problems. Opiate dependence is characterized by repeated self-administration that usually results in opiate tolerance, withdrawal symptoms, and compulsive drug-taking. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal.

PUBLIC WELFARE

Title 45. Public Welfare

45 CFR 1643.4

§ 1643.4 Applicability.

(a) Nothing in § 1643.3 shall be interpreted to apply to:

(1) The withholding or withdrawing of medical treatment or medical care;

(2) The withholding or withdrawing of nutrition or hydration;

(3) Abortion;

(4) The use of items, goods, benefits, or services furnished for purposes relating to the alleviation of pain or discomfort even if they may increase the risk of death, unless they are furnished for the purpose of causing or assisting in causing death, for any reason.

Alaska Statutes

CONTROLLED SUBSTANCES ACT

Title 11. Criminal Law;

Chapter 71. Controlled Substances

Title 17. Food and Drugs;

Chapter 30. Controlled Substances

Alaska Stat. § 11.71.900

Sec. 11.71.900. Definitions

In this chapter, unless the context clearly requires otherwise,

....

(19) "practitioner" means

(A) a physician, dentist, veterinarian, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in the state;

MEDICAL PRACTICE ACT

(No provisions found)

Title 8. Businesses and Professions;

Chapter 62. Medicine

PHARMACY PRACTICE ACT

Title 8. Businesses and professions;

Chapter 80. Pharmacists and Pharmacies

Alaska Stat. § 08.80.480

Sec. 08.80.480. Definitions

In this chapter, unless the context otherwise requires,

....

(28) "practitioner" means an individual currently licensed, registered, or otherwise authorized by the jurisdiction in which the individual practices to prescribe and administer drugs in the course of professional practice;

INTRACTABLE PAIN TREATMENT ACT

No Policy found

CONTROLLED SUBSTANCES REGULATIONS

No policy found

MEDICAL BOARD REGULATIONS (*No provisions found*)

Title 12. Professional Regulations;

Part 1. Boards and Commissions Subject to Centralized
Licensing; Chapter 40. State Medical Board

PHARMACY BOARD REGULATIONS (*No provisions found*)

Title 12. Professional Regulations;

Part 1. Boards and Commissions Subject to Centralized
Licensing;

Chapter 52. Board of Pharmacy

Appendix IV. Federal Regulations Related to Hospice Care

While state specific information is unavailable on the website of the National Hospice and Palliative Care Organization, their detailed list of hospice-related federal regulations is quoted below:

Federal Regulations:

Hospices are guided by regulations from a variety of federal agencies. The information below is a list of agencies that may have regulations that touch on hospice care. The Medicare hospice regulations can be found within the Centers for Medicare and Medicaid Services.

“Center for Disease Control

- Emergency Preparedness
- Infection Control

Centers for Medicare and Medicaid Services (CMS)

- Hospice Center
- Hospice Eligibility, Election, Revocation and Transfer
 - Election of hospice
 - Change (transfer) of designated hospice provider
 - Hospice eligibility requirements
 - Revocation of the Hospice Medicare Benefit
 - Discharge from Hospice Services
- CMS Hospice Change Requests
 - Change requests – 2012
 - Change requests – 2011
 - Change requests – 2010
 - Change requests – 2009
 - Change requests – 2008
 - Change requests – 2007
 - Change requests – 2006
 - Change requests – 2005
 - Change requests – 2004
 - Change requests – 2003
 - Change requests – 2002
 - Change requests – 2001
 - Change requests – 2000
- CMS Issues Questions and Answers
- Hospice Regulations
 - Code of Federal Regulations 42 CFR 418: Hospice Care
- Hospice Manuals
 - Medicare Benefit Policy Manual ; Chapter 9 - Coverage of Hospice Services Under Hospital Insurance
 - Medicare Claims Processing Manual ; Chapter 11 - Processing Hospice Claims

- State Operations Manual
- State Medicaid Manual; (See Section 4305 - Hospice Services)
- Medicare General Information, Eligibility, and Entitlement Manual ; Chapter 4 - Physician Certification and Recertification of Services- (See Section 60 - Certification and Recertification by Physicians for Hospice Care)
- Hospice Survey and Certification

Emergency Preparedness (Multiple federal agencies)

- Administration on Aging's Emergency Assistance Guidance
- Centers for Disease Control Emergency Preparedness

FEMA

- Resources for Private Sector
- Information for People with Disabilities
- Ready.gov
- State Emergency Preparedness Resources
- US Department of Agriculture
- US Department of Homeland Security
- US Food and Drug Administration

Drug Enforcement Agency (DEA)

Federal Trade Commission

Food and Drug Administration

Government Accountability Office

Medicare Payment Advisory Commission

US Department of Health and Human Services

- HIPAA 5010
- HIPAA Privacy and Security”²²⁸

Appendix V. Alaska Statute 13.52.010 – Advance Health Care Directives

“(a) Except as provided in Alaska Stat. § 13.52.173 , an adult may give an individual instruction. Except as provided in Alaska Stat. § 13.52.177 , the instruction may be oral or written. The instruction may be limited to take effect only if a specified condition arises.

(b) An adult may execute a durable power of attorney for health care, which may authorize the agent to make any health care decision the principal could have made while having capacity. The power remains in effect notwithstanding the principal's later incapacity and may include individual instructions. The power must be in writing, contain the date of its execution, be signed by the principal, and be witnessed by one of the following methods:

(1) signed by at least two individuals who are personally known by the principal, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgment of the signature of the instrument; or

(2) acknowledged before a notary public at a place in this state.

(c) Unless related to the principal by blood, marriage, or adoption, an agent under a durable power of attorney for health care may not be an owner, operator, or employee of the health care institution at which the principal is receiving care.

(d) A witness for a durable power of attorney for health care may not be

(1) a health care provider employed at the health care institution or health care facility where the principal is receiving health care;

(2) an employee of the health care provider providing health care to the principal, or of the health care institution or health care facility where the principal is receiving health care; or

(3) the agent.

(e) At least one of the individuals used as a witness for a durable power of attorney for health care shall be someone who is not

(1) related to the principal by blood, marriage, or adoption; or

(2) entitled to a portion of the estate of the principal upon the principal's death under a will or codicil of the principal existing at the time of execution of the durable power of attorney for health care or by operation of law then existing.

(f) Unless otherwise specified in the durable power of attorney for health care, the authority of an agent becomes effective only upon a determination that the principal lacks capacity and ceases to be effective upon a determination that the principal has recovered capacity.

(g) Unless otherwise specified in a written advance health care directive, a determination that a principal lacks or has recovered capacity, or that another condition exists that affects an individual instruction or the authority of an agent, shall be made by

(1) the primary physician, except in the case of mental illness;

(2) a court in the case of mental illness, unless the situation is an emergency; or

(3) the primary physician or another health care provider in the case of mental illness where the situation is an emergency.

(h) An agent shall make a health care decision in accordance with the principal's individual instructions, if any, and other wishes to the extent known to the agent. Otherwise, the agent shall make the decision in accordance with the agent's determination of the principal's best

interest. In determining the principal's best interest, the agent shall consider the principal's personal values to the extent known to the agent.

(i) A health care decision made by an agent for a principal is effective without judicial approval.

(j) A written advance health care directive may include the individual's nomination of a guardian of the individual.

(k) Except as provided in Alaska Stat. § 13.52.247 (a), an advance health care directive, including an advance health care directive that is made in compliance with the laws of another state, is valid for purposes of this chapter if it complies with this chapter, regardless of where or when it was executed or communicated.

(l) Notwithstanding the sample form provided under AS 13.52.300, an individual instruction that would be valid by itself under this chapter is valid even if the individual instruction is contained in a writing that also contains a durable power of attorney for health care and the durable power of attorney does not meet the witnessing or other requirements of this chapter.”²²⁹

End Notes

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- ³ World Health Organization. (2013) *Health topics: Health policy*. Accessed online May 30, 2013 from: http://www.who.int/topics/health_policy/en/
- ⁴ Frieden, TR. A Framework for Public Health Action: The Health Impact Pyramid. *American Journal of Public Health*. 2010 April; 100(4): 590-595. Accessed online May 30, 2013 from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/#!po=8.33333>
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- ⁶ Centers for Disease Control and Prevention, Division of Cancer Prevention and Control, Comprehensive Cancer Control Branch, Scientific Support and Clinical Translation Team. *Evidence-based Interventions (EBIs) for the National Comprehensive Cancer Control Program*. Last updated Jan. 31, 2013.
- ⁷ U.S. Department of Health and Human Services. *The Health Consequences of Smoking: A Report of the Surgeon General*. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004. Accessed online May 30, 2013 from: http://www.cdc.gov/tobacco/data_statistics/sgr/2004/index.htm
- ⁸ National Cancer Institute. State Cancer Profiles, Death Rate/Trend Comparison by Cancer, death years through 2009, US States versus US, All Cancer Sites, All Races, Both Sexes. Accessed and extracted data May 6, 2013 from: <http://statecancerprofiles.cancer.gov/cgi-bin/ratetrendbycancer/rtcancer.pl?001&0&00&00&1&0&1>
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- ¹³ State Cancer Profiles, Death Rate/Trend Comparison by State/County, death years through 2009. Alaska versus United States. All Races, Both Sexes. Accessed May 6, 2013 from: <http://statecancerprofiles.cancer.gov/cgi-bin/ratetrendbyarea/rtarea.pl?02&000&00&1&0&1>
- ¹⁴ Tobacco Prevention and Control Program, Section of Chronic Disease Prevention and Health Promotion. *Alaska Tobacco Facts, 2012 Update*. Accessed online May 9, 2013 from: http://dhss.alaska.gov/dph/Chronic/Documents/Tobacco/PDF/2012_alaska_tobacco_facts.pdf
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